PATIENT REGISTRATION JAIN DENTAL

Dr. MANOHAR JAIN

350 W. 22nd St. Suite #111
Lombard, IL-60148
Ph.: (630) 627 5400

PATIENT INFORMATION(INFORMACION DEL PACIENTE) **DATE(FECHA)____/____/____**

Patient Name(Nombre)_____
Last(Apellido) Name(Nombre) Middle

Birth Date (Fecha de Nacimiento(___/___/___ Age(Edad)____Sex(Sexo)____S.S.#_____

Patient Address_____
Street#(Calle Apt# City/Ciudad Estate/Estado Zip/codigo

Email_____Cell Phone#Cellular(___)_____-_____Phone(#Telefonico(____)____-_____

Employer Name _____Business Phone(# de Trabajo(____)_____-_____
(Nobre del trabajo)

Employer Address_____
Street(Calle) City/Ciudad, Estate/Estado,Zip/Codigo

Marital Status_____ Have we seen any other members of your family Y/N Who?_____

PERSON RESPONSIBLE FOR THE ACCOUNT (PERSONA RESPONSIBLE DE LA CUENTA)

Last(Apellido) Name(Nombre) Middle

Birth Date____/____/_____ Age (Edad)_____ Sex(Sexo)_____ S.S.#_____

Patient Address _____
(Domocilo) Street/Calle City/Ciudad, State/Estado,Zip/Codigo

Email_____Cell Phone#Cellular(___)_____-_____Phone(#Telefonico(____)____-_____

Employer Name _____Business Phone(# de Trabajo(____)_____-_____
(Nobre del trabajo)

Employer Address_____
Street(Calle) City/Ciudad, Estate/Estado,Zip/Codigo

MEDICAL HISTORY (HISTORICAL MEDICA)

YES/NO Are you under any medical treatment now (Esta bajo tratamiento medico?)_____
Yes/No Are you taking any medication?(Esta tomando medicamentos?)_____
Yes/No Are you allergic to any medication (Alerjia a algun medicamento)_____
Yes/No Have had any major surgery?(Alguna cirugia en el pasado?)_____
Yes/No Have you ever had any serious accident involving head/neck?_____
Yes/No Have you ever had any physical illness?(A tenido enfermedades fisicas?_____

HAVE EVER HAD ANY OF THE FOLLOWING?(A TENIDO ALGUNA DE LO SIGUIENTE?

Yes/No Heart Problems(Problemas Cardiacos)
Yes/No High/Low Blood Pressure (Presion alta_____
Yes/No Respiratory Distress(Problemas Respiratorios)
Yes/No Do you have Diabetes(Tiene Ustd Diabetes)
Yes/No Are you Pregnant(Esta en embarazo)

DENTAL HISTORY (HISTORIA DENTAL

Yes/No Do you have any specific problems(Problema especifico)_____
Yes/No Have you ever had Novocain Anesthetic? (Le an dado anestecia local?)
Yes/No Bleeding of the Gums?(Le sangran las encias
Yes/No When was your last full mouth x-ray(Cuando fue los ultimo rayos X de voca completa?

PATIENT AUTHORIZATION (AUTORIZACION DEL PACIENTE

I grant authorization to the Doctor in charge of the care of this patient, to administer any treatment such as anestheric or perform Operations if needed. (Yo le autorizo a el Doctor acargo, que le de tratamiento al paciente, como administrarle anestecia local o en dado cazo hacer cirugia Sie es necesario.)

X_____Relationship/Relacion_____