DATOS DE SALUD DEL PACIENTE

PARA PODERLE PROPORCIONAR UN SERVICIO DENTAL APROPIADO. TENGA LA BONDAD DE LLENAR LOS ESPACIOS EN BLANCO PARA DAR RESPUESTA A ALGUNAS PREGUNTAS QUE REQUIEREN OBSERVACION O INFORMACION ADICIONAL QUE USTED CONSIDERA QUE YO DEBO SABER.
GRACIAS POR SU COOPERACION .

FECHA

NOMBRE DEL PACIENTE (APELLIDO) (PRIMER) (INTIAL)

FECHA DE NACIMIENTO (SEXO) # SEGURO SOCIAL OCUPACION

DIRECCION DE RESIDENCIA (CALLE) (CUIDAD) (ZIP) TELEFONO

NOMBRE DEL SEGURO NOMBRE DEL EMPLEADO # SEGURO SOCIAL FECHA NACIMENTO

NOMBRE Y DIRECCION DEL TRABAJO (DEPT.) TELEFONO

NOMBRE DEL ESPOSO (A) TELEFONO

REFERIDO POR AMIGO CERCANO O FAMILIAR TELEFONO

ESTADO DE SALUD

EXCELENTE ( ) BUENA ( ) REGULAR ( ) POBRE ( )

NOMBRE DE SU MEDICO DIRECCION TELEFONO

- **ESTA USTED TOMANDO ALGUNA MEDICINA ACTUALMENTE ? SI ( ) NO ( ), CUALES SON, Y PARA QUE PROPOSITO**
- **ES USTED ALERGICO A : PENICILINA ( ) CODEINA ( ) ANESTESIA LOCAL ( ) ASPIRINA ( ) O A OTROS MEDICAMENTOS ( )**
- **SANGRA USTED POR LARGO TIEMPO? SI ( ) NO( ) TERAPIA DE RADIACION SI ( ) NO ( )**
- **ESTA USTED EMBARAZADA SI ( ) NO ( ) CUANTOS MESES TIENE?**

HA SIDO USTED TRATADO ALGUNA VEZ POR:

ENFERMEDAD DEL CORAZON—SI ( ) NO ( )
FIEBRE REUMATICA—SI ( ) NO ( )
PRESION ALTA O BAJA—SI ( ) NO ( )
ULCERAS—SI ( ) NO ( )
TUBERCULOSIS O ENFERMEDAD EN LOS PULMONES—SI ( ) NO ( )
DIABETES—SI ( ) NO ( )
EPILEPSIA—SI ( ) NO ( )
ANEMIA—SI ( ) NO ( )
LESION CONGENITA DEL CORAZON—SI ( ) NO ( )
EL VIRUS DEL SIDA—SI ( ) NO ( )
MURMULLO O SOPLO EN EL CORAZON—SI ( ) NO ( )
ICTERICIA—SI ( ) NO ( )
ASMA—SI ( )NO ( )
ALERGIA—SI ( )N0 ( )
SINUSITIS—SI ( )NO ( )
TOS—SI ( )NO ( )
HEPATITIS—SI ( ) NO ( )
ARTRITIS—SI ( ) NO ( )
EMBOLIA—SI ( ) NO ( )
GLAUCOMA—SI ( ) NO ( )

FIRMA DEL PACIENTE O CUSTODIO FECHA DOCTOR

INFORMACION E INSTRUCCIONES CONCERNIENTES A EXTRACCIONES SIMPLES

LUEGO DE UNA EXTRACCION

SANGRAR:

- MUERDA LA GAZA FIRMEMENTE POR UNA HORA . DESPUES DE UNA HORA , REMUEVA LA GAZA , ES RECOMENDABLE QUE SE TOME DOS PASTILLAS DE TYLENOL O IBUPROFEN AHORA,Y REPETIR, DOS PASTILLAS CADA CUATRO HORAS. CIERTA CANTIDAD DE SANGRAMIENTO ES NORMAL LUEGO DE UNA EXTRACCION, PERO SI CONTINUAS SANGRANDO FUERTE, REPITA EL PROCESO DE MORDER UNA GAZA POR UNA HORA . EVITE EJERCICIOS .

DOLOR:

- CIERTA CANTIDAD DE DOLOR ES COMUN DESPUES DE UNA EXTRACCION , SI EL TYLENOL O ADVIL NO ES SUFICIENTE,DEBE DE OBTENER UNA RECETA.

HINCHAZON:

- PARA REDUCIR LA HINCHAZON DESPUES DE UNA EXTRACCION COMPLICADA APLIQUE UNA BOLSA DE HIELO EN LA CARA SOBRE EL LUGAR OPERADO, CADA 15 MINUTOS.

ENJUAGUES BUCALES:

- LAVADO VIGOROSO DE LA BOCA PUEDE CAUSAR MAS SANGRAMIENTO. NO SE ENJUAGUE LA BOCA HASTA EL SIGUIENTE DIA CON UNA SOLUCION DE AGUA Tibia Y SAL,
  (1 CUCHARADA) 5-10 VECES AL DIA POR SIETE DIAS.
  DURANTE EL PROCESO DE SANACION , TRATAR DE NO COMER EN EL LADO OPERADO,
  Y EVITE ALIMENTOS DIFICILES DE MASTICAR .

FRAGMENTOS DE HUESO :

- DURANTE EL PROCESO DE SANACION PEQUENOS FRAGMENTOS DE HUESO PUEDEN DESPRENDERSE , ESTOS HUESOS NO SON RAICES Y GENERALMENTE SON EXPULSADOS POR SI MISMOS , PERO SI SON MOLESTOS , REGRESE A LA OFICINA PARA REMOVERLOS.

DOLOR E HINCHAZON :

- SI ESTOS OCURREN LUEGO DE SANAR LA HERIDA, VENGA A LA OFICINA PARA EXAMINARLE.

EN CASO DE CUALQUIER PROBLEMA O PREGUNTAS CONTACTENOS

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.