DRS ENSOR JOHNSON & LEWIS

Pediatric Dentistry

Date/*Fecha*:_____

Personal History:

Name/*Nombre*: _____ Nickname/*Apodo*:_____

Age/*Edad*:_____ Date of Birth/*Fecha de Nacimiento*:_____ Sex/*Sexo*:_____

School/*Escuela*:_____ Grade/*Grado*:_____

Children in Family/# *Niños en Familia*:_____ Referred By/*Referidos Por*:_____

Home Address/*Direccion*:_____ City/State/Zip:_____

Home Phone/*Tel Casa*:_____ Email/*Correo Electronico*:_____

Father's Name/*Padre*:_____ Parent's Occupation/*Ocupacion*:_____

Cell Phone/*Tel Celular*:_____ Work Phone/*Tel Trabajo*:_____

Mother's Name/*Madre*:_____ Parent's Occupation:_____

Cell Phone/*Tel Celular*:_____ Work Phone/*Tel Trabajo*:_____

Person Responsible for Account/*Persona Responsable de la Cuenta*:_____

Medical History:

Patient Physician/*Doctor Primaria*:_____

Date of Most Recent Exam/*Fecha de Ultimo Examen*:_____

Has the patient ever had any of the following conditions? (Circle if Yes)
El paciente alguna vez tuvo alguna de las condiciones? (Circule Abajo)

Heart Disease, Rheumatic Fever, Brain Injury, Seizures, Skin Disorders, Asthma, Ear Infections, Tonsillitis, Bleeding Disorders, Kidney Involvement, Liver Involvement, HIV-Positive/AIDS, Other

If Other, please explain/*Otra condicion, por favor explique*:_____

_____

Is the patient allergic to any foods or medicine/*Alguna alergia a comida o medicina*? Yes_____No_____

Has the patient ever had Penicillin/*Alguna vez tomaron Penicilina*? Yes____No_____

Has the patient ever been hospitalized/*Alguna vez fueron hospitalizado*? Yes_____No____

The Dental Practice of Drs Ensor Johnson & Lewis
11810 Parklawn Drive, Suite 101, North Bethesda, MD 20852
(P) 301-881-6170 ● (F) 301-231-9659 ● info@ejldental.com ● www.ejldental.com

DRS ENSOR JOHNSON & LEWIS

Dental History/*Historia Dental*:

Reason for this visit (check-up, toothache, etc.)/*Razon de visita (chequeo, dolor, etc..)*?

_____

_____

Is this the patient's first visit to the dentist/*Primera visita al dentista*? Yes___No_____

When was the patient's last dental visit/*Cuando era la última visita al dentista*? _____

_____

Service rendered at that time/*Servicios recividos*?_____

Has the patient ever had any unfavorable dental experience/*Tuvo alguna experiencia mala con un dentista*? Yes_____No____

Please explain if the answer is yes/*Por favor explique*: _____

_____

Have there been any injuries to the patient's teeth/*Alguna historia de lesión a los dientes*? Yes____No_____

Please explain if the answer is yes/*Por favor explique*:_____

_____

Does/Did the patient suck his/her thumb, fingers, pacifier or lips? Yes_____No____
El paciente se chupa o chupaba el dedo, labio, o chupón?

If yes, until what age/*hasta que edad*?_____

Has the patient had any previous orthodontic care? Yes____No_____
El paciente alguna vez tuvo tratamiento de Ortodoncia?

If yes, when/*Si, Cuando*?_____

Parent or Guardian Name/*Nombre de Padre*:_____

Parent or Guardian Signature/*Firma*:_____

APPOINTMENTS: Once an appointment has been made, please remember this time has been reserved especially for you. If you miss your appointment without proper notification, a $50 charge will be assessed. To avoid this charge, please call the office to reschedule your appointment at least 48 hours in advance.

CITAS: Después de hacer una cita, por favor acuérdese que ese tiempo ha sido reservado para usted. Si usted no viene a la cita sin notificar a la oficina se le cobrara $50. Para evitar este cargo, por favor llame la oficina para cambiar la cita o cancelarla con por lo menos 48 horas en adelanto.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears above, to administer any treatment agreed upon; or to administer local anesthetics, agents or drugs; to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Yo doy autorización a l(a/os) dentista(s) a cargo del paciente cuyo nombre aparece arribe; administrar el tratamiento acordado y/o administrar anestesia; y practicar operaciones que puedan ser necesarias o aconsejables para el diagnóstico y tratamiento del paciente.

Signature/Firma:_____
(Parent or Guardian if Patient is Under 18)
(Padre o Guardián si el paciente es menor de 18 años)

The Dental Practice of Drs Ensor Johnson & Lewis
11810 Parklawn Drive, Suite 101, North Bethesda, MD 20852
(P) 301-881-6170 ● (F) 301-231-9659 ● info@ejldental.com ● www.ejldental.com