Clínica de Ortodoncia y Dental Ángeles
Av. Madero # 1390-6 entre Calles E y F
Colonia Nueva, Mexicali, Baja California

Date: _____

CLINIC FILE

Name: _____

Age: _____ Gender: _____ Date of birth: _____

Address:

_____

City, State: _____ Home phone number: _____

Occupation: _____ Mobile phone number: _____

E-mail: _____

Reason of visit: _____

In case of emergency call to: _____

Last visit to the dentist:_____ _____

In the following list, please mark YES or NO have you suffered or suffer from any of the following diseases:

Epilepsy or seizures	NO ☐	YES ☐	Anemia	NO ☐	YES ☐
Heart attack	NO ☐	YES ☐	Hepatitis	NO ☐	YES ☐
Hyper or Hypothyroidism	NO ☐	YES ☐	Asthma	NO ☐	YES ☐
Low or High Blood Pressure	NO ☐	YES ☐	Diabetes	NO ☐	YES ☐
Kidney disease	NO ☐	YES ☐	Tuberculosis	NO ☐	YES ☐
AIDS	NO ☐	YES ☐	H.I.V. / SIDA	NO ☐	YES ☐
Gastritis	NO ☐	YES☐	Menopause	NO ☐	YES ☐
Pregnancy	NO ☐	YES ☐	Cancer	NO ☐	YES ☐
Allergies	NO ☐	YES ☐	Explain: _____		

C.D.E.O Sindy Anahogui Sauceda Gastélum Cédula 11055205
C.D. Vicente Dinael Cota Ramírez Cédula 7590964

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Do you have any disease not mentioned here?
Explain:

_____

_____

If you are being treated by a doctor, write down the date of the last appointment: _____

Reason: _____

Are you taking any medication? : NO ☐ YES ☐
If you say YES, please write the medications here:

Drug name	Dose:	Since when:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many times do you brush your teeth a day? _____

Mouthwash: NO ☐ YES ☐ Frequency: _____

Floss: NO ☐ YES ☐ Frequency: _____

Do you smoke?: NO ☐ YES ☐ Frequency: _____

Alcoholic beverages?: NO ☐ YES ☐ Frequency: _____

Drugs?: NO ☐ YES ☐ Frequency and kind: _____

By signing this document, I declare that I have answered all the questions that have been asked, without omitting anything, about my conditions, diseases, treatments and in general about my health (required or not by the dentist). In the event that there is no specific condition of my own within the questioning, I will let the dentist know immediately.

Name: _____ Signature _____

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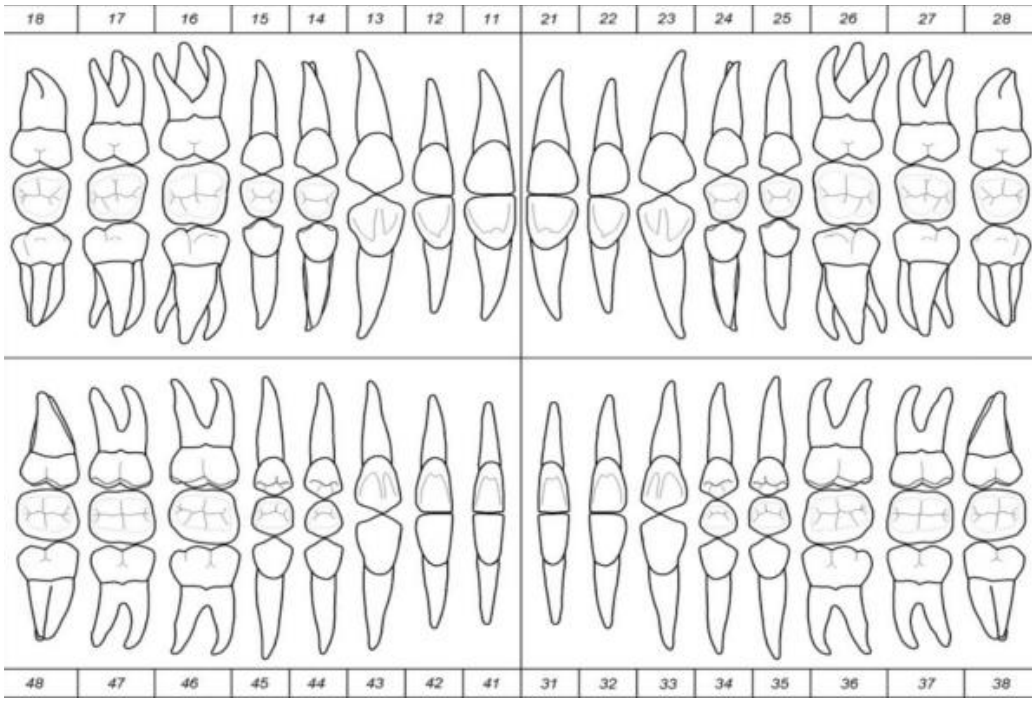

TOOTH	DIAGNOSIS

C.D.E.O Sindy Anahogui Sauceda Gastélum — Cédula 11055205
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INFORMED CONSENT AND ACCEPTANCE OF TREATMENT

I_____,
hereby give my consent and authorize the dental treatments described in the estimate (also signed by me) and treatment plan to be carried out.

I declare that the different treatment options have been explained to me, the times and number of appointments required for each one, as well as their costs.

I am aware of the advantages and disadvantages of each of them and the consequences of not carrying it out. I am fully aware that during the treatment pain, inflammation and some other discomfort may occur, which is a consequence of the treatment itself, and if is necessary, medication will be prescribed to reduce said discomfort.

Likewise, I hereby authorize the collection of the estimate and the fees for said services, as well as the payment conditions that have been exposed to me, expressing my agreement with this contract entered into by mutual agreement between both parties.

I have had the opportunity to ask and receive answers about all of the above, therefore I release this clinic from any civil, criminal or any kind of responsibility for the actions that apply to this treatment.

It has been explained to me that a lack of hygiene can harm my oral health and that I must attend regular inspection, control and cleaning appointments every 6 months (or less if necessary), to guarantee the work carried out here.

The warranty of the work will only be valid if I comply with the above and follow the instructions of the doctors.

_____ _____

Patient name and signature | Dentist name and signature

_____ _____

Witness | Witness

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