Appointments from
9:00am -1:00pm and
3:pm- 6:00pm
Monday – Friday, Saturday 9am – 2pm
Av. Ignacio Comonfort 9350 Int. 204
Zona Rió, Tijuana B.C.
Phone: Mexico (664) 684-7285
Phone: USA (858) 768-9937

MEDICAL HISTORY

Name_____ Gender_____ Date of Birth_____ Age_____

Marital Status_____ Occupation _____ Home Address_____

_____

Mailing Address, if different from home address:

_____ Phone _____

Religion_____ Education_____ Email_____

How did you hear about us: _____

GUARDIAN IF PATIENT IS A MINOR OR DISABLED

Name_____ Address _____

_____Phone _____ Date of Birth _____

Relationship to patient _____

FAMILY HISTORY

	Hypertension	Diabetes	Cancer	Cardiac	Genetic	Neurological
Grandparents	_____	_____	_____	_____	_____	_____
Parents	_____	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____	_____
Uncles	_____	_____	_____	_____	_____	_____

PERSONAL PATHOLOGICAL HISTORY

What Illnesses have you suffered from? _____
Infectious and contagious disease as a child? _____

Surgeries?_____Traumas?_____Allergies?_____

_____Paracites? _____ Infections? _____HIV, Hepatitis, Herpes,

Papilloma?_____Degenerative or Malignant?_____Poisoning and other

addictions? _____Ex-Smoker_____Ex-Alchoholic_____Ex-Addict_____

Congenital?_____Other_____

NON-PATHOLOGICAL HISTORY

Nutritional Status_____ Nutrition?_____

DrugAddictions?_____Smoke?_____Drink?_____Other?_____

Income_____ Personal Hygene?_____Oral Hygene_____

Risk Factors in the area where you live?_____

CURRENT CONDITION

Reason for your visit today._____Date_____

_____

HOUR	DATE	START	CURRENT CONDITION	SYMPTOMS	THERAPEUTIC TREATMENTS

INFORMED CONSENT TO TREATMENT

TIJUANA BAJA CALIFORNIA, Date_____ 201____.

I HEREBY GIVE MY CONSENT AND AUTHORIZATION TO RECEIVE DENTAL CARE AT THIS OFFICE, I have had the opportunity to seek other medical and dental opinions and to receive answers for the questions I had of my current dental condition, I agree and request that the Dentist ……..……
……..

and dental auxiliaries, perform the medical and dental treatments and procedures in my mouth to regain my health. I am aware of the advantages that are explained to me verbally and in writing of the procedures that will be performed for each of the treatments that are aimed at regaining my health and I am fully aware of the disadvantages and risks that the dentist has explained to me verbally which are risks such as, but not limited to the following; the risks that may occur before, during, or after the treatment may include: mild or serious injury, inflammation, hardening of tissue, trismus, pain, tumefaction, mild or severe infections, anesthesia, paresthesia, loss of the tooth being treated, tooth loss after treatment, infectious process, alveolar bone loss, dental ankylosis, arrhythmias, syncope, fainting, stroke, cardiac arrest, abortion, and even death. The dental work done by the dentist will be noted on the "Treatment and Progress" form, with date, time, exerted treatment, as well as the treatments and procedures aimed to recover the health of the patient. The making of this medical history form has been formed according to the official Mexican norms: NOM 013-SSA2-2006 and NOM-168-SSA1-1998, such consent and authorization has a duration of 5 years from the date of the cited case. **Aware of this as a patient, I give my consent, authorization and acceptance of treatment to regain my health. I have been informed that the required treatments will be performed by dentists certified by the Mexican Secretariat of Public Education, who provide treatment in Tijuana, Baja California, Mexico. As a result, we subject ourselves to arbitration of the Medical Arbitration Commission of Baja California in Mexico and the jurisdiction of the authorities and courts of Baja California, in the Mexican republic exclusively.**

Patient's Full Name or Guardian's _____

Signature _____

LIKEWISE I AUTHORIZE THE DENTIST AND HEALTH PERSONNEL FOR CONTINGENCIES AND EMERGENCY CARE ARISING FROM THE AUTHORIZED PROCEDURE: administering anesthetics, antibiotics, analgesics, and any other drug cabinet or laboratory studies deemed necessary for the fulfillment of the treatment, and the necessary surgical procedures, aimed at regaining my health. I have been informed beforehand: that drug therapy and some dental treatments can cause slight discomfort, injury, pain, allergy, and in advanced infectious cases the loss of life itself when infectious processes present or disseminated are in an advanced stage in the patient. Aware of this as a patient and noting that every part of my dental treatment is aimed at regaining my health, I agree that there has not been any fraud, deceit, or bad faith done to me as a patient at any time and with this I agree to release the surgeon and health personnel of any administrative, civil, and criminal responsibility, for actions in the exercise of their profession taken to solve my dental care, and of any medical data not mentioned by me as a patient. I

have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient's Full Name or Guardian's _____

Signature _____

Full Name of Witness _____

Signature _____