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| 1. **DATOS DE IDENTIFICACIÓN**
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| **NOMBRE COMPLETO** |  |
| **TIPO DE DOCUMENTO** |  | **NUMERO** |  |
| **CÓDIGO** |  | **EDAD** |  |
| **FECHA DE NACIEMIENTO** |  | **ESTADO CIVIL** |  |
| **SEXO** | M | F | **TELEFONO** |  |
| **FECHA DE INSCRIPCIÓN** |  |
| **DIRECCIÓN** |  |

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| 1. **ANAMNESIS**
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| --- | --- | --- | --- | --- | --- |
|  | Si | No |  | Si | No |
| 1. Alergias |   |   | 9. VIH |   |   |
| 2. Hemorragias |   |   | 10. Cirugías (incluso dentales) |   |   |
| 3. Radioterapias |   |   | 11. Exodoncias |   |   |
| 4. Hipertensión |   |   | 12. Hepatitis |   |   |
| 5. Diabetes |   |   | 13. Patologías respiratorias |   |   |
| 6. Tratamiento médico actual |   |   | 14. Convulsiones |   |   |
| 7. Toma de medicamentos |   |   | 15. Enfermedades orales |   |   |
| 8. Embarazo |   |   | 16. Enfermedades gástricas |   |   |

MOTIVO DE CONSULTA:

Observaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **EXAMENES: ESTOMATOLOGO-TEJIDOS BALNDOS- HALLAZGOS**
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| 1. LABIOS |  |
| 2. LENGUA |  |
| 3. CARRILLOS |  |
| 4. PISO DE BOCA |  |
| 5. PALADAR |  |
| 6. FRENILLOS |  |

Observaciones:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **PRÓTESIS**
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| Presencia de prótesis | Si | No |   | Higiene oral | B |   | R |   | M |   |
| Descripción: | Frecuencia de cepillado | 1 |   | 2 |   | 3 |   |
| Seda dental: | SI | NO |

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| 1. **ANÁLISIS A.T.M**
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|  | Si | No |  | Si | No |
| 1. Dolor muscular |   |  | 3. Ruido articular |   |   |
| 2. Dolor articular |   |   | 4. Limitación del movimiento |   |   |

Observaciones:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **F. CONTROL DE PLACA** |

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| D | M | A |
|   |   |   |

 55 54 53 52 51 61 62 63 64 65 Fecha

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| No de superficies con placa |
|   |

 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

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| Índice de placa |
|   % |

**** 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

1. 84 83 82 81 71 72 73 74 75

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| **G. ODONTOGRAMA** |

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 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

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**** 55 54 53 52 51 61 62 63 64 65****

 85 84 83 82 81 71 72 73 74 75



 48 46 47 45 44 43 42 41 31 32 33 34 35 36 37 38

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| **H. LECTURA RX** |
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| **I. DIAGNOSTICO** |
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|   | No |
| Cariados |   |
| Obturados |   |
| Exfoliados |   |
| Sanos |   |

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| **J. PLAN DE TRATAMIENTO** |
| **OPERATORIA** |  | **ENDODONCIA** |  | **PERIODONCIA** |  |
| **CIRUGÍA ORAL** |  | **MD ORAL** |  | **CIRUGÍA MAXILO FACIAL** |  |
| **HIGIENE ORAL** |  | **REHABILITACIÓN ORAL** |  | **ORTODONCIA** |  |

**\*Consentimiento informado**

Por medio de la presente constancia, en pleno uso de mis facultades mentales, otorgo en forma libre mi consentimiento al doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ para que por su intermedio en ejercicio legal de su profesión, así como de los demás profesionales de la salud que se requiere, y con el concurso del personal auxiliar de servicios asistenciales de la entidad, se me practique los procedimientos por mi conocidos de acuerdo a los diagnósticos y plan de tratamiento por el realizado y plenamente informado.

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fecha Firma del odontólogo Firma del paciente

Nombre del paciente:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ identificación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Fecha |  | Diente | Actividad | Descripción del procedimiento | Firma |
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