

**PATIENT INFORMATION**

Date \_\_\_\_\_

Mr. Mrs. Ms. Dr. First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Sex: Male Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Tel. (\_\_\_\_\_) \_\_\_\_\_ Cell. (\_\_\_\_\_) \_\_\_\_\_ Have you ever been a patient of our practice? Yes No  
 Dentist \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Referred by \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Telephone (\_\_\_\_\_) \_\_\_\_\_

**Who will be responsible for your account?**

Self Spouse Father Mother Other \_\_\_\_\_

(If self, skip to next section)

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Telephone (\_\_\_\_\_) \_\_\_\_\_

**Spouse or other guarantor information (if different from above)**

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Telephone (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**Student:** Full Time Part Time Not

Married Divorced Legally Separated Widow Single

**Employed:** Full Time Part Time Retired Not

**PRIMARY DENTAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
**Ins. Co. Name** \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name** \_\_\_\_\_  
**Insured Party** \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex: Male Female Birth Date \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. (\_\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**PRIMARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
**Ins. Co. Name** \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name** \_\_\_\_\_  
**Insured Party** \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex: Male Female Birth Date \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. (\_\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
**Ins. Co. Name** \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name** \_\_\_\_\_  
**Insured Party** \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex: Male Female Birth Date \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. (\_\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_  
**Ins. Co. Name** \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ Tel. (\_\_\_\_\_) \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name** \_\_\_\_\_  
**Insured Party** \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex: Male Female Birth Date \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. (\_\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**HEALTH HISTORY**

**To our patients:** Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit _____	Yes	No
1. Are you in good health? _____ Height _____ Weight _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health in the past year? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you under the care of a physician? _____ Date of last visit _____	<input type="checkbox"/>	<input type="checkbox"/>
<i>If so, for what are you being treated?</i>		
4. Do you have a prosthetic joint/implant? If so, describe where _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a heart valve replacement or vascular graft? _____	<input type="checkbox"/>	<input type="checkbox"/>

**HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .**

	Yes	No	NOTES
6. Rheumatic fever?			
7. Damaged heart valves/mitral valve prolapse?			
8. Heart murmur?			
9. High blood pressure?			
10. Low blood pressure?			
11. Chest pain/angina?			
12. Heart attack(s)?			
13. Irregular heart beat?			
14. Cardiac pacemaker?			
15. Heart surgery?			
16. Bronchitis, chronic cough?			
17. Asthma?			
18. Hay fever/sinus problems?			
19. Snoring/sleep apnea?			
20. Difficult breathing/other lung trouble?			
21. Tuberculosis?			
22. Emphysema?			
23. Do you smoke?			
24. Do you use chewing tobacco?			
25. Blood transfusion?			
26. Blood disorder such as anemia?			
27. Bruise easily?			
28. Bleeding tendency/abnormal bleed?			
29. Hepatitis, jaundice, or liver disease?			
30. Infectious mononucleosis?			

**MEDICATION. Are you now taking . . .**

	Yes	No	NOTES
56. Any kind of medication, drugs, or pills?			
57. Blood thinners (Coumadin, Aspirin, Advil)?			
58. Any natural, herbal or homeopathic remedy?			
59. Please list all medications you are taking:			

**MEDICATION. Are you now taking . . .**

	Yes	No	NOTES
70. Is there a possibility of pregnancy?			
71. Expected delivery date _____			
72. Are you nursing?			
73. Are you taking birth control pills?			

**Women Note:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Home Tel. (\_\_\_\_\_) \_\_\_\_\_ Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **X** \_\_\_\_\_ Reviewed by: **X** \_\_\_\_\_ Date: **X** \_\_\_\_\_  
(Parent or Guardian if minor)

I authorize Dr. Meltzer and his designated staff, to perform periodontal implant and/or TMJ examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

**X** \_\_\_\_\_ **X** \_\_\_\_\_ Witness: **X** \_\_\_\_\_  
 Date Signature of patient (Parent or Guardian if minor) Doctor: **X** \_\_\_\_\_

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) **X** \_\_\_\_\_ Date: **X** \_\_\_\_\_

**HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .**

	Yes	No	NOTES
31. Gallbladder trouble?			
32. Fainting spells?			
33. Convulsions/epilepsy?			
34. Stroke?			
35. Thyroid trouble?			
36. Diabetes?			
37. Low blood sugar?			
38. Kidney trouble?			
39. Are you on dialysis?			
40. Swollen ankles, arthritis or joint disease?			
41. Stomach ulcers?			
42. Contagious diseases?			
43. HIV/AIDS?			
44. Sexually transmitted diseases?			
45. Problems with the immune system?			
46. A tumor or growth?			
47. Radiation therapy/chemotherapy?			
48. Chronic fatigue/night sweats?			
49. A history of drug abuse?			
50. A history of alcohol abuse?			
51. Contact lenses?			
52. Eye disease/glaucoma?			
53. Mental health problems?			
54. A removable dental appliance?			
55. Pain and clicking of jaws when eating?			

**ALLERGIES. Are you allergic to or had a reaction to . . .**

	Yes	No	NOTES
60. Local anesthetic (numbing med.)?			
61. Penicillin?			
62. Other antibiotics?			
63. Sulfa Drugs?			
64. Sodium pentothal, Valium, or other tranquilizers?			
65. Aspirin?			
66. Codeine or other narcotics?			
67. Other medications?			
68. Latex?			

69. Please list any allergies other than drug allergies:

Is there any condition concerning your health that the Doctor should be told about?  
 Yes  No (if so, describe) \_\_\_\_\_  
 Do you wish to speak to the doctor privately about anything?  Yes  No