**Robert J. Pelzar, D.M.D.**
**Alek Klebaner, D.D.S.**
990 Laurel Street, Suite A
San Carlos, CA 94070
(650) 592-3436 • Fax (650) 654-1847

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM *(Please Print)*

Date _____

## PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____ Home Phone ( ) _____
Number, Street

Cell Phone ( ) _____

City _____ Zip _____ Social Security # _____

Marital Status _____ Sex M _____ F _____ Name of Spouse _____

Occupation _____ Driver's License # _____ Employer _____

Employer's Address _____ Work Phone ( ) _____
Street City Zip

Person to notify in emergency _____ Relationship _____ Phone ( ) _____

Are you a student? _____ yes _____ no If yes, name of school _____

Whom may we thank for referring you to our office? _____

## PERSON RESPONSIBLE FOR PAYMENT

(If Other Than Patient)

Name _____ Social Security # _____

Address _____ Driver's License# _____

City _____ Zip _____

Occupation _____ Length of Employment _____

Employer _____ Phone ( ) _____

Address _____ City _____ Zip _____

## DENTAL INSURANCE INFORMATION

| | (First Carrier) | (Second Carrier) |
|---|---|---|
| Name of Employee | | |
| Employee's Birthdate | | |
| Employee's SS# | | |
| Name of Employer | | |
| Insurance Company | | |
| Address or P.O. Box | | |
| City, State and Zip | | |
| Phone # of Ins. Co. | | |
| Group or Policy# or Local# | | |

***IMPORTANT- All Patients Please Sign***

I agree to have my signature considered to be "on file" for the purposes of insurance form processing; I also agree to be responsible for payment for any service or portion of service not covered by insurance.
I authorize release of necessary information relating to the processing of dental insurance forms. In order for us to process your insurance forms more rapidly and to assist you in getting all the benefits to which you are entitled, please sign and date below.

Signature ("On File") _____ Date _____

(OVER)

# HEALTH HISTORY

**It is important that we know your Medical and Dental History. These facts have a bearing on your dental health. Please fill in items as completely as possible.**

## MEDICAL HISTORY

1. Do you have any current health problem? ☐ Yes ☐ No
   If yes, what? _____
2. Are you under the care of a physician? ☐ Yes ☐ No
   If yes, for what condition? _____
3. Name of your physician _____ Phone _____
   Address _____
4. Are you taking any medication or drug? (Including non-prescription)
   If yes, what? _____ ☐ Yes ☐ No
   _____
   _____
5. Have you ever had any serious illness or operation?
   If yes, what? _____ ☐ Yes ☐ No
   _____
   _____

Have you ever had any of the following, please check yes or no.

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Fainting Spells/Convulsions |
| ☐ | ☐ | Shortness of Breath on Mild Exertion | ☐ | ☐ | Hepatitis |
| | | | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Persistent Cough/ Cough up Blood |
| ☐ | ☐ | Heart Murmur | | | |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | History of Diabetes in Your Family |
| ☐ | ☐ | Congenital Heart Disease | | | |
| ☐ | ☐ | Tightness in Chest | ☐ | ☐ | Artificial Heart Valve |
| ☐ | ☐ | Jaundice/Liver Disease | ☐ | ☐ | Cardiac Pacemaker |
| ☐ | ☐ | Arthritis or Painful Swollen Joints | ☐ | ☐ | HIV Positive Status |
| | | | ☐ | ☐ | A.I.D.S. |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Venereal Diseases (Syphilis, Gonorrhea) |
| ☐ | ☐ | Anemia | | | |
| ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Emphysema |
| ☐ | ☐ | Kidney/Bladder Disease | ☐ | ☐ | Asthma |
| ☐ | ☐ | Tumors/Growths | ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Artificial Prosthesis (Implants) | ☐ | ☐ | Stroke |
| ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Marked Weight Gain |
| ☐ | ☐ | Latex Allergy | | | |

Have you ever become sick from, shown allergy to or been told not to take:

☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs
☐ Codeine or Narcotics ☐ Anesthesia (Novocaine)
☐ Others _____

Have you ever taken Fen-Phen, Redux or any other diet pills? ☐ Yes ☐ No
Have you ever taken Biphosphonates (Fosamax, etc.) ? ☐ Yes ☐ No

WOMEN
Are you taking Birth Control Pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____

## DENTAL HISTORY

1. Purpose of this visit: _____
2. How long since you have seen a dentist? _____
3. Last full mouth X-Rays. Date: _____
4. Last Dental treatment. Date: _____
5. Name of former dentist: _____
6. Have you come to this office for pain relief? ☐ Yes ☐ No
7. Where is the pain? _____
8. How does it hurt? ☐ with Hot? ☐ with Cold? ☐ with Sweets?
9. Have you ever had any injury to your face or jaw? ☐ Yes ☐ No
   If yes, please explain _____
10. Do you grind your teeth? ☐ Yes ☐ No
11. Have you ever had clicking or popping near your ear when you chew? ☐ Yes ☐ No
12. Do your gums bleed? ☐ Yes ☐ No
13. Have you had (gum) Periodontal surgery? ☐ Yes ☐ No
14. Have you ever had unfavorable experience from local anesthetic? ☐ Yes ☐ No

Is there any other Medical or Dental Information that you feel we should know about? _____
_____
_____
_____
_____
_____

## MEDICAL HISTORY REVIEW

_____ _____
Doctor's Signature Date

| Date | Initials | Date | Initials |
|---|---|---|---|
| | | | |
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| | | | |
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| | | | |
| | | | |

Completed at later appts.

I confirm as true the above health information.
CONSENT. I hereby authorize the dentist to take x-rays, study models, photographs or any aids deemed appropriate by the dentist in charge of my care to make a thorough diagnosis of my (or the patient's) dental needs. I also authorize the dentist to preform any and all forms of treatment, medication and therapy that may be indicated.

Signature _____ Date _____