Robert J. Pelzar, D.M.D.
Alek Klebaner, D.D.S.
501 Walnut Street
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 _____ Sex M ◯ F ◯

Address _____ Home Phone ( ) _____

City _____ Zip _____ Cell Phone ( ) _____

Email: _____ Work Phone ( ) _____

Marital Status _____ Name of Spouse _____ Social Security # _____

Occupation _____ Employer _____

Employer's Address _____ Driver's License # _____

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 this 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, Zip		
Phone# of Ins. Co.		
Group or Policy# or Local#		

IMPORTANT-All Patients Please Sign

I agree to have my signature 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.
A charge may be made for broken appointments unless the courtesy of forty-eight hours notice has been given.

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
			◯	◯	Venereal Diseases (Syphilis, Gonorrhea)
◯	◯	High Blood Pressure			
◯	◯	Anemia	◯	◯	Emphysema
◯	◯	Excessive Bleeding	◯	◯	Asthma
◯	◯	Kidney/Bladder Disease	◯	◯	Stroke
◯	◯	Tumors/Growths	◯	◯	Marked Weight Gain
◯	◯	Artificial Prosthesis (Implants)			
◯	◯	Radiation Therapy			
◯	◯	Latex Allergy			

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

☐ 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, Boniva, Actonel, Reclast, 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

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 _____