

**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

Date _____

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

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 _____ Date _____
("On File")

(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.

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;"><input type="checkbox"/> Yes</td><td style="width: 50%;"><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> Heart Disease</td><td><input type="checkbox"/> Epilepsy</td></tr> <tr><td><input type="checkbox"/> Rheumatic Fever</td><td><input type="checkbox"/> Fainting Spells/Convulsions</td></tr> <tr><td><input type="checkbox"/> Shortness of Breath on Mild Exertion</td><td><input type="checkbox"/> Hepatitis</td></tr> <tr><td><input type="checkbox"/> Heart Surgery</td><td><input type="checkbox"/> Tuberculosis</td></tr> <tr><td><input type="checkbox"/> Heart Murmur</td><td><input type="checkbox"/> Persistent Cough/Cough up Blood</td></tr> <tr><td><input type="checkbox"/> Heart Attack</td><td><input type="checkbox"/> Diabetes</td></tr> <tr><td><input type="checkbox"/> Mitral Valve Prolapse</td><td><input type="checkbox"/> History of Diabetes in Your Family</td></tr> <tr><td><input type="checkbox"/> Congenital Heart Disease</td><td><input type="checkbox"/> Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/> Tightness in Chest</td><td><input type="checkbox"/> Cardiac Pacemaker</td></tr> <tr><td><input type="checkbox"/> Jaundice/Liver Disease</td><td><input type="checkbox"/> HIV Positive Status</td></tr> <tr><td><input type="checkbox"/> Arthritis or Painful Swollen Joints</td><td><input type="checkbox"/> A.I.D.S.</td></tr> <tr><td><input type="checkbox"/> High Blood Pressure</td><td><input type="checkbox"/> Venereal Diseases (Syphilis, Gonorrhea)</td></tr> <tr><td><input type="checkbox"/> Anemia</td><td><input type="checkbox"/> Emphysema</td></tr> <tr><td><input type="checkbox"/> Excessive Bleeding</td><td><input type="checkbox"/> Asthma</td></tr> <tr><td><input type="checkbox"/> Kidney/Bladder Disease</td><td><input type="checkbox"/> Hay Fever</td></tr> <tr><td><input type="checkbox"/> Tumors/Growths</td><td><input type="checkbox"/> Stroke</td></tr> <tr><td><input type="checkbox"/> Artificial Prosthesis (Implants)</td><td><input type="checkbox"/> Marked Weight Gain</td></tr> <tr><td><input type="checkbox"/> Radiation Therapy</td><td></td></tr> <tr><td><input type="checkbox"/> Latex Allergy</td><td></td></tr> </table> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting Spells/Convulsions | <input type="checkbox"/> Shortness of Breath on Mild Exertion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Persistent Cough/Cough up Blood | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> History of Diabetes in Your Family | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> HIV Positive Status | <input type="checkbox"/> Arthritis or Painful Swollen Joints | <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Diseases (Syphilis, Gonorrhea) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Stroke | <input type="checkbox"/> Artificial Prosthesis (Implants) | <input type="checkbox"/> Marked Weight Gain | <input type="checkbox"/> Radiation Therapy | | <input type="checkbox"/> Latex Allergy | | <table style="width: 100%; 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| <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting Spells/Convulsions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Shortness of Breath on Mild Exertion | <input type="checkbox"/> Hepatitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Persistent Cough/Cough up Blood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> History of Diabetes in Your Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Artificial Heart Valve | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Cardiac Pacemaker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> HIV Positive Status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Arthritis or Painful Swollen Joints | <input type="checkbox"/> A.I.D.S. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Diseases (Syphilis, Gonorrhea) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Hay Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Artificial Prosthesis (Implants) | <input type="checkbox"/> Marked Weight Gain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Radiation Therapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Latex Allergy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting Spells/Convulsions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Fainting Spells/Convulsions | <input type="checkbox"/> Hepatitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Persistent Cough/Cough up Blood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Persistent Cough/Cough up Blood | <input type="checkbox"/> Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Diabetes in Your Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> History of Diabetes in Your Family | <input type="checkbox"/> Artificial Heart Valve | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cardiac Pacemaker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> HIV Positive Status | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> HIV Positive Status | <input type="checkbox"/> A.I.D.S. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Venereal Diseases (Syphilis, Gonorrhea) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Venereal Diseases (Syphilis, Gonorrhea) | <input type="checkbox"/> Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Marked Weight Gain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Marked Weight Gain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Have you ever become sick from, shown allergy to or been told not to take:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine or Narcotics | <input type="checkbox"/> Anesthesia (Novocaine) | |
| <input type="checkbox"/> 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? _____

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 perform any and all forms of treatment, medication and therapy that may be indicated.

Signature _____ Date _____

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.