Allan Melnick, D.D.S.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Tell Us About Yourself

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ Social Security #: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

City: _____ State: _____ Zip Code: _____ Driver's License #: _____

Home Phone #: _____ Cell #: _____ Work #: _____ Ext: _____

Where/when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Neighbor or relative not living with you

Name: _____ Relationship: _____

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Spouse Information

Name: _____ Birthdate: _____ SS#: _____

Employer: _____ Work Phone #: _____ Cell Phone #: _____

City: _____ State: _____ Zip Code: _____ Drv. License #: _____

Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Street/PO Box City State Zip Code

Insurance Co. Phone #: _____ Group #: _____

Insured's Name: _____ Subscriber ID #: _____

Insured's Birthdate: _____ Insured's SS #: _____ Relationship to Patient: _____

Insured's Employer: _____

Employer's Address: _____

Street/PO Box City State Zip Code

Secondary Dental Insurance

Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Street/PO Box City State Zip Code

Insurance Co. Phone #: _____ Group #: _____

Insured's Name: _____ Subscriber ID #: _____

Insured's Birthdate: _____ Insured's SS #: _____ Relationship to Patient: _____

Insured's Employer: _____

Employer's Address: _____

Street/PO Box City State Zip Code

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before treatment today? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Y ☐ N Brush daily? ☐ Y ☐ N

Type of bristles on toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Are your teeth sensitive to heat, cold, anything else? _____

Do you have mobility in your teeth? ☐ Y ☐ N

Do you still have wisdom teeth? ☐ Y ☐ N

Previous/Present Dentist: _____ Last visit? _____

(Please Circle)

Would you like fresher breath ☐ Y ☐ N Whiter teeth ☐ Y ☐ N

Are you happy with the way your smile looks? ☐ Y ☐ N

If not, what would you change? _____

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Date of last visit? _____

Your current health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Y ☐ N

Have you ever taken Bisphosphonates? ☐ Y ☐ N

For Women: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Y ☐ N

Week #: _____ Are you nursing? ☐ Y ☐ N

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congen. Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Value Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

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Medical History Update

I have read my medical history dated _____ and confirm that it states past and present medical condition.

Signature _____ Date _____

I have read my medical history dated _____ and confirm that it states past and present medical condition.

Signature _____ Date _____