Elaine Torres-Melendez, DMD, FACP | Practice Limited to Prosthodontics
Patient Medical History

Basic Information

Patient's name (Last, First)	Birth date	Today's date	Date of last visit

Address	City, State	Zip

Home phone	Work phone	Cell phone	Email address
( ) -	( ) -	( ) -	

Social Security number	Marital status/partner	Who referred you?

Person responsible for this account	Phone	Emergency contact	Phone

Dental Insurance plan	ID/group number	Secondary insurance plan	ID/group number

Physician	Physician phone	Pharmacy	Pharmacy phone

Medical Information

Sex:	Do you smoke or use tobacco?
Women, please answer the following:	
Are you taking birth control pills? Y N	Are you pregnant? How many weeks? Y N
Do you use any hormonal contraception? Y N	Are you nursing? Y N

Do you have, or have had, any of the following conditions? If so, please circle:

Abnormal bleeding
Alcohol abuse
Allergies
Anemia
Angina pectoris
Arthritis
Artificial bones
Artificial heart valve
Artificial joints
Asthma
Blood transfusion
Cancer or chemotherapy
Colitis
Congenital heart defect
Cosmetic surgery
Diabetes (type I or type II?)
Difficulty breathing
Drug abuse
Emphysema
Epilepsy
Fainting spells
Fever blisters
Frequent headaches
Glaucoma
HIV/AIDS
Hay fever
Heart attack
Heart surgery
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
High blood pressure
Kidney problems
Liver disease
Low blood pressure
Mental health concerns
Mitral valve prolapse
Pacemaker
Radiation therapy
Rheumatic fever
Seizures
Shingles
Sickle cell disease
Sinus problems
Stroke
Thyroid problems
Tuberculosis
Ulcers
Venereal disease

Allergies and Medications

Do you have allergies to any of the following substances? If so, please circle:

Medications	**Substances**	**Foods**
Aspirin	Jewelry	Eggs
Codeine	Latex	Milk
Dental anesthetics	Metals	Peanuts
Erythromycin	Seasonal allergies	Fish
Penicillin		Shellfish
Tetracycline		
Other:	Other:	Other:
_____	_____	_____

Which medications are you currently taking? Please include dosage and time of day taken:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Is there any disease, condition, or problem that you would like Dr. Torres-Melendez to know about? If yes, please use the space below to describe.

By signing below, you authorize release of your dental records to aid in dental evaluation and treatment. You further certify that all the information on this form is correct and truthful.

You also agree to pay for services rendered and/or in agreement with a treatment plan presented by Elaine Torres-Melendez, DMD. Payment will be made at time of service.

Date: _____

Patient signature: _____

Should you break or cancel an appointment with less than forty-eight (48) hours notice, or if you fail to appear for an appointment, you will incur a fee. The period of 48 hours does not include the time between Friday after 3 pm and Monday before 8 am.