

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

Allergies and Medications

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

Medications

Aspirin
Codeine
Dental anesthetics
Erythromycin
Penicillin
Tetracycline
Other:

Substances

Jewelry
Latex
Metals
Seasonal allergies
Other:

Foods

Eggs
Milk
Peanuts
Fish
Shellfish
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.