MELANCON FAMILY DENTISTRY

Matthew Melancon, D.D.S. **300 West Madison Street, Broussard, LA**
337-837-1861 **www.melancondentistry.com**

Date_____

1. Patient's Name_____ Preferred Name_____
Last First Middle
2. Address_____
Street City State Zip
3. Home Phone _____ Cell Phone _____ Work Phone _____
4. E-Mail Address _____ Sex____ Marital Satus S___ M___ W___ D___
5. Birth date _____ Social Security _____ Driver's License _____
6. How would you prefer to be contacted for appointment confirmation? (please circle) Call Text Email

7. Person Responsible for Payment _____Driver's License _____
Last First Middle
8. Address_____
Street City State Zip
9. Home Phone _____Cell Phone _____ Work Phone _____
10. E-Mail Address _____Birth date _____ Social Security _____
11. Relationship to Patient _____If minor, other parent's name _____
12. Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION (Please present card)

13. Insured's Name _____If the insured is the patient or responsible party, skip to question 17.
14. Insured's Birth date _____
15. Insured's Address _____
16. Insured's Social Security ____
17. Insured's Employer _____
18. Insured's Company Name _____Group Number _____
19. Insurance Address _____ Phone number_____

EMERGENCY INFORMATION

20. Local Friend or Relative not living with you _____
21. Complete Address _____
22. Phone_____ Cell _____

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicted in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, the doctor and/or his team will give full explanation of the procedure(s) involved. I agree to pay for all service rendered by this office.

Our office reserves the right to cancel/reschedule if appointments can not be confirmed within 24 hours of appointment time.

Signature of responsible party_____ Date _____

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MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   If yes, for what reason? _____

2. Please provide the name, address, and telephone number of your physician.

   _____

3. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No

   If yes, for what reason? _____

4. Have you had any excessive bleeding of any kind requiring special treatment? ☐ Yes ☐ No
5. Have you taken any medication or drugs during the last two years? ☐ Yes ☐ No
6. Are you allergic to or made sick by penicillin, aspirin, codeine or any medications? ☐ Yes ☐ No

   If yes, please list _____

7. List all medications you are taking at this time _____

   _____

8. Do you ever have to stop walking or climbing stairs because of pain in your chest, shortness of breath or fatigue? ☐ Yes ☐ No
9. Do your ankles swell during the day? ☐ Yes ☐ No
10. Have you lost or gained 10 pounds in the last year? ☐ Yes ☐ No
11. Are you on a special diet? ☐ Yes ☐ No
12. Has your medical doctor said you have cancer or a tumor? ☐ Yes ☐ No
13. Do you use more than two pillows to sleep? ☐ Yes ☐ No
14. Do you wake up from sleep short of breath? ☐ Yes ☐ No
15. Are you taking birth control pills? ☐ Yes ☐ No
16. Are you pregnant? If yes, what month are you due? _____ ☐ Yes ☐ No

17. Check any of the following that you have had or have at present:

☐ Heart Failure	☐ Shortness of breath	☐ HIV Positive (AIDS)
☐ Heart Disease or Attack	☐ Emphysema	☐ Hepatitis A (Infectious)
☐ Angina Pectoris (Chest Pain)	☐ Hepatitis B (Serum)	☐ High Blood Pressure
☐ Tuberculosis (TB)	☐ Liver Disease	☐ Heart Murmur/Mitral Valve
☐ Asthma	☐ Yellow Jaundice	☐ Bruise Easily
☐ Rheumatic Fever	☐ Hay Fever	☐ Blood Transfusion
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Drug Addiction
☐ Scarlet Fever	☐ Diabetes	☐ Hemophilia
☐ Artificial Heart Valve	☐ Thyroid Disease	☐ Cold Sores or Fever Blisters
☐ Heart Pacemaker	☐ X-Ray or Cobalt Treatment	☐ Epilepsy or Seizures
☐ Heart Surgery	☐ Chemotherapy (Cancer, Leukemia)	☐ Fainting or Dizzy Spells
☐ Artificial Joint	☐ Arthritis	☐ Nervousness
☐ Anemia	☐ Rheumatism	☐ Psychiatric Treatment
☐ Stroke	☐ Cortisone Medication	☐ Sickle Cell disease
☐ Kidney Trouble	☐ Glaucoma	☐ Acid Reflux
☐ Ulcers	☐ Pain in Jaw Joints	☐ Healing Complications

Please record any disease, condition or problem not listed: _____

Updates (date and initial) _____ _____ _____ _____ _____ _____ _____ _____