Dr. Luke Klele DMD 931 Hamburg Turnpike, Wayne, NJ 07470, 973•553•2512

Patient Information

Date__________________ Home (___)_______________ Cell (___)_____________

Name________________________________ SS/HC/Patient ID #__________________
Last Name First Middle Initial

Address______________________________ E-Mail ____________________________

City_________________________________ State __________ Zip _______________ Sex □Male

□Female Age______ Birthdate______________ □Married □ Widowed

□ Separated □ Divorced □ Partnered for___years Patient

Employer/School_______________________ Occupation__________________________ Employer/School

Address______________________ Employer/School Phone (___)_____________

Primary Insurance Person Responsible for
Account____
Last Name First Name Middle Initial

Relation to Patient________________ Birth date_____________ Soc. Sec.# __________

Address (If different from patient's) _________________________ Phone (___)__________________

City_______________________________ State _____________ Zip_________________ Person

Responsible Employed by ________________________ Occupation_________ Business Address

___________________________________ Phone (___) ___________ Insurance

company____ Contract

#_________________ Group #_________________ Subscriber #___________ Names of other

dependents covered under this plan ______________________________ Additional

Insurance

Is patient covered by additional insurance? □ Yes □ No Subscriber Name________________ Birth date

_________ Relation to Patient ________ Address (If different from patient's)_________________________

Phone (___)_______________ City___________________________ State______________

Zip___________________

Subscriber Employed by ______________________ Business Phone (___)___________

Insurance Company__________________________ Soc. Sec. #____________________
Contract #_________________________ Group #____________ Subscriber #________ Names of other dependents covered under this plan_______________________________________ Dental History
Reason for Today's Visit____________________ Date of last dental care_____________________

Former Dentist___________________________ Date of last dental X-rays__________________

Address____

Check if you have had problems with any of the following:
□Bad breathe □Grinding teeth □Sensitivity to hot
□Bleeding gums □Loose teeth or broken filling □Sensitivity to sweets
□Clicking or popping jaw □Periodontal treatment □Sensitivity when biting
□Food collection between teeth □Sensitivity to cold □Sores or growths in your mouth How often do you floss?_________________ How often do you brush?___________________

Medical History

Physician's Name _________________________ Date of Last Visit_____________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □Yes □No

Have you ever had a serious illness of operations? □Yes □No If yes, describe______________________

Have you ever had a blood transfusion? □Yes □No If yes, give approxiamate dates____________ (Women) Are you pregnant? □Yes □No Nursing? □Yes □No Taking birth control pills? □Yes □No

Check if you have or have had any of the following:
□Anemia □Cortisone Treatments □Hepatitis □Scarlet Fever
□Arthritis □Cough, Persistent □High Blood Pressure □Shortness of breath
□Artificial Heart Valves □Cough up Blood □HIV/AIDS □Skin Rash
□Artificial Joints □Diabetes □Jaw Pain □Stroke
□Asthma □Epilepsy □Kidney disease □Swelling of Feet/Ankles
□Back Problems □Fainting □Liver disease □Thyroid Problems
□Blood Disease □Glaucoma □Miral Valve Prolapse □Tobacco Habit
□Cancer □Headaches □Pacemaker □Tonsillitis
□Chemical Dependency □Heart Murmur □Radiation Treatment □Tuberculosis
□Chemotherapy □Heart Problems □ Respiratory Disease □Ulcer
□Circulatory Problems □Hemophillia □Rheumatic Fever □Venereal Disease

Medications Allergies List medications you are currently taking:

Authorization I certify that I, and/or my dependent(s), have insurance coverage with ______________________and assign directly to Dr.__________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and disclose such information to the above-names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Rep Date Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.