PATIENT HISTORY **TODAY'S DATE**_____

LAST NAME FIRST NAME/MI

ADDRESS CITY/ST ZIP CODE

PHONE NUMBER ( )_____-_____ BIRTH DATE MONTH _____ DAY _____ YEAR _____ SOCIAL SECURITY NUMBER _____-_____-_____

DENTAL INSURANCE: **DO YOU HAVE ANY DENTAL INSURANCE COVERAGE?** **(Y)** **(N)**

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

GROUP NAME_____ GROUP NAME_____

ID OR POLICY #_____ ID OR POLICY #_____

INSURED SOC SEC #_____ INSURED SOC SEC#_____

EMPLOYMENT INFORMATION:

EMPLOYER'S NAME_____ WORK PHONE_____

EMPLOYER'S ADDRESS_____

DRIVER LICENSE_____

APPLICABLE SPOUSE INFORMATION

SPOUSE'S FULL NAME_____ WORK PHONE_____

SPOUSE'S EMPLOYER_____ BIRTHDATE_____

SOCIAL SECURITY NUMBER_____

REASON FOR LEAVING FORMER DENTIST?_____

WHAT IS YOUR REACTION TO DENTAL WORK? **PLEASE CIRCLE.**

A. DREAD IT. B. WORRY ABOUT IT. C. DON'T MIND IT.

IS THIS VISIT FOR A CHECK–UP OR FOR A SPECIFIC PROBLEM? PLEASE STATE.

_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PATIENT SURVEY – PLEASE CHECK APPROPRIATE BOX	**YES**	**NO**
1). DO YOU LIKE THE APPEARANCE OF YOUR TEETH?	( )	( )
2). WOULD YOU LIKE TO HAVE WHITER TEETH?	( )	( )
3). DO YOUR GUMS BLEED WHEN BRUSHING?	( )	( )
4). DOES FOOD CATCH BETWEEN YOUR TEETH?	( )	( )
5). ARE YOUR TEETH SENSITIVE TO		
HEAT	( )	( )
COLD	( )	( )
SWEETS	( )	( )
BITING PRESSURE	( )	( )
6). DO YOU HAVE SPACES BETWEEN YOUR TEETH?	( )	( )
7). DO YOU PREFER WHITE FILLINGS INSTEAD OF SILVER?	( )	( )
8). DO YOU EXPERIENCE UNPLEASANT MOUTH ODOR OR TASTE?	( )	( )

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE VINCENT COLONNA DMD TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY DENTAL TREATMENT AND I HEREBY ASSIGN TO THE DENTIST ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE **SIGNATURE**

_____

PLEASE CONTINUE FORM ON BACK OF THIS PAGE.

CLINICAL BACKGROUND INFORMATION **PATIENT HISTORY CONTINUED**

1). PERSONAL PHYSICIAN (IF ANY)

DOCTOR'S NAME CITY/ST PHONE NUMBER

2). APPROXIMATE DATE OF LAST MEDICAL EXAMINATION?_____

3). APPROXIMATE DATE OF LAST DENTAL EXAMINATION?_____

4). DO YOU HAVE ANY HISTORY OF:	PLEASE CHECK YES	NO	FOR DOCTOR'S USE ONLY (Specify, if any are checked yes)
HEART DISEASE?	( )	( )	
HIGH OR LOW BLOOD PRESSURE?	( )	( )	
DIABETES?	( )	( )	
ASTHMA OR OTHER LUNG DISEASE?	( )	( )	
KIDNEY DISEASE?	( )	( )	
RHEUMATIC FEVER/HEART MURMUR?	( )	( )	
JOINT REPLACEMENT?	( )	( )	
CONVULSIONS?	( )	( )	
HEPATITIS OR OTHER SERIOUS ILLNESS?	( )	( )	
REACTION TO ANESTHESEIA OF ANY KIND?	( )	( )	
HEART VALVE REPAIR OR REPLACEMENT?	( )	( )	
HIV/AIDS?	( )	( )	
5). DO YOU HAVE ANY DRUG ALLERGIES OR OTHER SERIOUS ALLERGIES?	( )	( )	
6). HAVE YOU EVER HAD PROLONGED BLEEDING AFTER CUTS OR EXTRACTIONS?	( )	( )	
7). HAVE YOU EVER BECOME ILL OR HAD COMPLICATIONS FOLLOWING DENTAL TREATMENT?	( )	( )	
8). IF YOU ARE A WOMAN, ARE YOU PREGNANT?	( )	( )	
9). DO YOU TAKE ANY PILLS OR MEDICINES?	( )	( )	
10). DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS?			
CORTISONE?	( )	( )	
TRANQUILIZERS?	( )	( )	
INSULIN?	( )	( )	
BLOOD THINNERS?	( )	( )	
ANTI-HYPERTENSIVES?	( )	( )	
BIRTH CONTROL?	( )	( )	
OSTEOPOROSIS MEDICATION?	( )	( )	

IF YES, SPECIFY ALL ALLERGIES:

A)_____ B)_____

B)_____ D)_____

OTHER? PLEASE SPECIFY._____

11). **IF YOU HAVE ANY REASON TO BELIEVE YOU ARE NOT PRESENTLY IN GOOD HEALTH OR IF YOU HAVE EVER BEEN HOSPITALIZED OR HAD ANY OPERATIONS OR IF OTHER MEDICAL INFORMATION ABOUT YOU IS IMPORTANT FOR US TO KNOW, PLEASE BRIEFLY EXPLAIN:**

12). SIGNATURE:_____

(If patient is a minor, parents or authorized guardian must sign)