For Office Use Only

X-rays ______________________

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MARTIN L. KOLINSKI, D.D.S., LTD.
TRICIA R. CROSBY, D.D.S., M.S.

Dental Implants • Periodontics

525 Tyler Road, Suite E
St. Charles, Illinois 60174
www.mkolinski.com
Tel: 630.377.4677
Fax: 630.377.5075

Welcome to Our Practice!

Today's Date ____/____/____

PATIENT INFORMATION

Patient Name ____
First   Middle Initial   Last   Mr. / Mrs. / Ms. / Miss

Nickname ______________________ ❑ Male ❑ Female ❑ Single ❑ Married

Social Security # ______________________ Birth Date ________/________/________

Phone #'s (_____)______________ (_____)______________ (_____)______________
Home   Work   Cell

Address ____
Street

____
City   State   Zip Code

E-Mail Address ____

Responsible Party ____
Parent/Guardian

Whom may we thank for referring you? ______________________________

EMERGENCY INFORMATION

In case of emergency, who should we notify?: ______________________________

Phone # (_____)______________________ Second Phone # (_____)______________________

DENTAL INSURANCE (PRIMARY)

Subscriber's Name ____
First   Middle Initial   Last

Relationship to Patient ____

Subscriber's Social Security # ______________________ Subscriber's I.D.# ______________________

Subscriber's Birth Date ______/________/_____ Subscriber's Employer ______________________

Status: ❑ Full Time ❑ Part Time ❑ Retired

Subscriber's Insurance Co. ______________________ Subscriber's Group # ______________________

DENTAL INSURANCE (SECONDARY)

Subscriber's Name ____
First   Middle Initial   Last

Relationship to Patient ____

Subscriber's Social Security # ______________________ Subscriber's I.D.# ______________________

Subscriber's Birth Date ______/________/_____ Subscriber's Employer ______________________

Status: ❑ Full Time ❑ Part Time ❑ Retired

Subscriber's Insurance Co. ______________________ Subscriber's Group # ______________________

CONFIDENTIAL DENTAL HISTORY

Reason for Today's Visit? ______________________________

General Dentist: ______________________________ **Date of Last Visit:** ________________

Check (✔) if you have had problems with any of the following

- ☐ **Bad breath**
- ☐ **Bleeding gums**
- ☐ **Clicking or popping jaw**
- ☐ **Difficulty chewing**
- ☐ **Digestive problems**
- ☐ **Facial pain**
- ☐ **Food collection between teeth**
- ☐ **Gagging easily**
- ☐ **Grinding teeth**
- ☐ **Limited jaw opening**
- ☐ **Loose teeth or broken teeth**
- ☐ **Facial/jaw numbness**
- ☐ **Periodontal treatment**
- ☐ **Poorly fitting dental appliance**
- ☐ **Sensitivity**
- ☐ **Sores or growths in your mouth**
- ☐ **Teeth do not match properly**

Have you ever had any complications following dental treatment? ☐ **Yes** ☐ **No**

If yes, please explain: ______________________________

Do you need antibiotic premedication prior to dental treatment? ☐ **Yes** ☐ **No** **Prescription:** ____________________

Do you have back or neck pain when sitting or leaning back? ☐ **Yes** ☐ **No**

CONFIDENTIAL MEDICAL HISTORY

Physician's Name ______________________________ **Date of Last Visit** ____________

PhoneNumber ______________________________

Have you ever had the following? Please check (✔) those that apply:

- ☐ **Anemia**
- ☐ **Arthritis/Rheumatism**
- ☐ **Artificial Joint/Heart Valve**
- ☐ **Asthma/Hay Fever**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Diabetes** **(excessive urination or thirst)**
- ☐ **Dizziness/Fainting Tendency**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Head/Facial Injury**
- ☐ **Heart Disease**
  - ☐ **Chest Pain**
  - ☐ **High Cholesterol**
- ☐ **Heart Murmur**
- ☐ **Hemophilia**
- ☐ **Herpes**
- ☐ **HIV/AIDS**
- ☐ **High/Low Blood Pressure**
- ☐ **Jaundice/Hepatitis: Type** _____
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Lung Disease**
  - ☐ **Shortness of Breath**
- ☐ **Mental Disorders**
- ☐ **Nervous Disorders**
  - ☐ **Anxiety**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Currently Pregnant**
  - ☐ **Due Date:** _________
  - **or** ☐ **Nursing:** _________
- ☐ **Radiation/Chemotherapy**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin, Pondimin and Redux.
☐ Yes ☐ No

Have you ever taken any bisphosphonate type drugs which include Fosamax, Actonel, Boniva, Zometa and Aredia?
☐ Yes ☐ No If yes, for how long? ________Years ________Months

Do you smoke? ☐ Yes ☐ No **Do you use alcohol** on a daily basis? ☐ Yes ☐ No

Allergies, i.e., food, drugs, latex, local anesthetic? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Kolinski and his staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Kolinski.

I authorize my insurance company to pay to Dr. Kolinski all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize Dr. Kolinski to release all information necessary to secure the payment of benefits. I understand that I am fully financially responsible for all charges whether covered or not covered or denied by my insurance company.

Since at each visit Treatment Plans are presented and the care to be provided is explained to me prior to treatment, I give Dr. Kolinski my consent to perform any needed dental treatment, including the use of local anesthetic as needed.

Date: ____________________ Signature: ______________________________
Patient/Parent/Guardian

CURRENT MEDICATIONS / UPDATED MEDICATIONS

Please list **ALL** prescription, over-the-counter (including **daily aspirin therapy**), and herbal medications you are currently taking. Also, please list the dosage, reason for each medication, and if the medication was prescribed by your physician.

Mo/Yr	Name of Medication	Dosage	Reason	Prescribed by Your Physician	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

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MEDICAL / DENTAL HEALTH UPDATE

☐ **No change in health status**

List any change in health status: ____________________

____

Reason for today's visit ____________________

List any changes in address/ insurance information ____________________

____

Patient Signature ____________________ **Date:** __________

Reviewed ____________________ **Date:** __________

MEDICAL / DENTAL HEALTH UPDATE

☐ **No change in health status**

List any change in health status: ____________________

____

Reason for today's visit ____________________

List any changes in address/ insurance information ____________________

____

Patient Signature ____________________ **Date:** __________

Reviewed ____________________ **Date:** __________

MEDICAL / DENTAL HEALTH UPDATE

☐ **No change in health status**

List any change in health status: ____________________

____

Reason for today's visit ____________________

List any changes in address/ insurance information ____________________

____

Patient Signature ____________________ **Date:** __________

Reviewed ____________________ **Date:** __________