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

For Office Use Only

X-rays _____

_____

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:** ____________