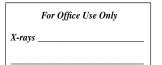
MARTIN L. KOLINSKI, D.D.S., LTD. TRICIA R. CROSBY, D.D.S., M.S.



Dental Implants • Periodontics

525 Tyler Road, Suite E St. Charles, Illinois 60174

www.mkolinski.com



Welcome to Our Practice!

Today's Date//				
		PATIENT INFORMATION	ON	
Patient Name				
	First	Middle Initial	Last	Mr. / Mrs. / Ms. / Miss
Nickname				Single Married
Social Security #		Birth Date	/	/
Phone #'s ()	Home	()	()_	Cell
Address				
		Street		
E-Mail Address	City		State	Zip Code
Responsible Party				
Whom may we thank for		Parent/Guardiar	1	
whom may we mank for		EMERGENCY INFORMA		
In case of emergency, who				
Phone # ()		Second Phor	ne # ()	
	DE	NTAL INSURANCE (PRI	MARY)	
Subscriber's Name				
	First	Middle	Initial	Last
Relationship to Patient				
Subscriber's Social Securit	ty #		_Subscriber's I.D.#	
Subscriber's Birth Date	/	_ Subscriber's Employe	r	
Status: 🔲 Full Time	☐ Part Time	☐ Retired		
Subscriber's Insurance Co).	9	Subscriber's Group #	
		TAL INSURANCE (SEC		
		TAL INSURANCE (SEC	DNDART)	
Subscriber's Name	First	Middle	Initial	Last
Relationship to Patient				
Subscriber's Social Securit	ty#		_Subscriber's I.D.#	
Subscriber's Birth Date	/	_ Subscriber's Employe	r	
Status:	Part Time	☐ Retired		
Subscriber's Insurance Co)		Subscriber's Group # _	

	CONFIDENTIAL DENTAL HISTO	RY
Reason for Today's Visit?		
General Dentist:		Date of Last Visit:
Check (/) if you have had problem	s 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 complication	s following dental treatment? Yes	□No
If yes, please explain:	•	
		☐ No Prescription:
Do you have back or neck pain when		<u> </u>
	CONFIDENTIAL MEDICAL HISTO	DRY
Physician's Name		Date of Last Visit
Phone Number		Bate of East Visit
Have you ever had the following? P	lease check (/) those that annive	
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 Have you ever taken any of the grou of Ionimin, Adipex, Fastin, Pondimin Yes No Have you ever taken any bisphosphelication of Information I	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 p of drugs collectively referred to as and Redux. onate type drugs which include Fosar 3? Years Mo Do you use alcohol on a daily basis? I anesthetic? ☐ Yes ☐ No	Sinus Problems Stomach Problems Stroke Thyroid Disease Tuberculosis Tumors Ulcers Venereal Disease "Fen-Phen?" These include combinations max, Actonel, Boniva, Zometa and Aredia? onths Yes No
used by Dr. Kolinski and his staff to help dete will inform Dr. Kolinski.	rmine appropriate and healthful dental treati	nowledge. I understand that this information will be nent. If there is any change in my medical status, I
	. I authorize Dr. Kolinski to release all inform	payable to me for services rendered. I authorize use ation necessary to secure the payment of benefits. I overed or denied by my insurance company.
Since at each visit Treatment Plans are present consent to perform any needed dental treatment.		o me prior to treatment, I give Dr. Kolinski my eeded.
Date: Signate	ure:	

Patient/Parent/Guardian

CURRENT MEDICATIONS / UPDATED MEDICATIONS

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	
		- <u></u>		Yes	No	
FOR OFFIC	E USE ONLY					
		MEDICAL / DENTAL H	HEALTH UPDATE			
No chan	ge in health status					
	ange in health status:					
Elective Cir						
Reason for						
	anges in address/ insurance					
Pationt Sign		Date:				
raticiti 516.				Date.		
Reviewed ₋				Date:		
		MEDICAL / DENTAL I	HEALTH UPDATE			
No chan	ge in health status					
List any ch	ange in health status:					
Reason for	today's visit					
List any ch	anges in address/ insurance	information				
Patient Sig	nature			Date:		
				.		
Reviewed ₋				Date:		
		MEDICAL / DENTAL I	HEALTH UPDATE			
	ge in health status					
List any ch	ange in health status:					
	today's visit					
L1st any ch	anges in address/ insurance	intormation				
Patient Sig	nature			Date:		