Martin L. Kolinski, D.D.S.
Tricia R. Crosby, D.D.S., M.S.

Dental Implants • Periodontics

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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**
- ☐ **Anxiety**
- ☐ **Arthritis/Rheumatism**
- ☐ **Artificial Joint/Hip/Knee**
- ☐ **Asthma/Hay Fever**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chest Pain**
- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Fainting Tendency/Dizziness**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Head/Facial Injury**
- ☐ **Heart Disease**
  - ☐ **Chest Pain**
  - ☐ **High Cholesterol**
- ☐ **Heart Murmur/Mitral Valve**
- ☐ **Hemophilia**
- ☐ **Herpes**
- ☐ **HIV/AIDS**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Kidney Problems**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Lung Disease**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Psychiatric Problems**
- ☐ **Radiation Chemotherapy**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Shortness of Breath**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**
- ☐ **Other Condition**

_____
_____
_____

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

Are you currently... ☐ **pregnant ?** ☐ **nursing ?** ☐ **using birth control ?**

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 either Dr. Kolinski or Dr. Crosby and their staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Kolinski or Dr. Crosby.

I authorize my insurance company to pay to either Dr. Kolinski or Dr. Crosby all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize Dr. Kolinski or Dr. Crosby 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 or Dr. Crosby 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

FOR OFFICE USE ONLY

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:** __________

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Patient Consent Form and FAX Privacy Waiver

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this contract. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Our office will communicate with you regarding your appointments in our office. Should you not be able to take our phone call, we will leave a message regarding the necessary information or request you to return our call regarding other pertinent information. Your signature will allow us to leave the above messages on an answering machine, voice mail or through another person.

I understand that my medical record may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Martin L. Kolinski, D.D.S. and Tricia R. Crosby, D.D.S., M.S. of all liability. I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date