Drs. Colasanto and Monfared, P.C.
Endodontics, Periodontics, and Implant Dentistry

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Please Circle: Mr. / Mrs. / Ms. / Dr. / Fr. / Hon. / Other_____

First Name_____ Middle Initial_____ Last Name _____

Date of Birth_____SSN _____

Home Address _____

City_____ State_____ Zip _____

Home Tel: _____ Work Tel: _____ Cell _____

Email _____ Preferred Phone Number: Home Work Cell

Employer _____ Occupation _____

Pharmacy Phone #/ Address _____

Emergency Contact Name and Phone_____

Relationship to Patient _____ Name of Spouse_____

Name of General Dentist _____ Referred by_____

EMPLOYER AND DENTAL INSURANCE INFORMATION

Insurance Company Name, Address, Phone No._____

_____ ID # _____

Group #_____Relationship to Policy Holder (Self, Spouse, Child) _____

Policy Holder's Name _____ Policy Holder's SSN_____

Policy Holder's Birth Date_____ Policy Holder's Employer _____

IF THE PATIENT IS A MINOR, PLEASE LIST THE PERSON WHO IS LEGALLY RESPONSIBLE

Name _____ Relationship to patient _____

Address _____

Home Tel _____Work Tel_____ Cell _____

Date of Birth _____ SSN _____

DENTAL HISTORY

Reason for today's visit? _____

Do you currently have any of the following?

□ Bad breath	□ Grinding or clenching teeth	□ Sensitive to hot
□ Bleeding gums	□ Oral sores or growths	□ Sensitive to sweets
□ Difficulty opening mouth/ TMJ pain	□ History of periodontal treatment	□ Sensitive when biting
□ Food collection between teeth	□ History of orthodontic treatment	□ Spontaneous pain
□ Shifting or movement of teeth	□ Sensitive to cold	□ Other:_____

Have you ever had an injury to your face or jaws? □ Yes □ No _____

MEDICAL HISTORY

Primary Physician's name _____ Date of last visit _____

Have you had any serious illnesses or been hospitalized in the past five years? □ Yes □ No

If yes, please describe _____

(Women Only) Are you pregnant? □ Yes □ No If Yes, what month? _____ Nursing? □ Yes □ No

Taking birth control pills? □ Yes □ No

Are you allergic or have had an adverse reaction to any of the following medications or substances?

□ Aspirin	□ Erythromycin	□ Local Anesthetic	□ Tetracycline
□ Clindamycin	□ Ibuprofen	□ Penicillin	□ Tylenol
□ Codeine	□ Latex	□ Sulfa	□ NO ALLERGIES

□ Other: Please list: _____

Please check any of the following which you currently have or have had in the past:

□ Arthritis, Rheumatism	□ Drug / Alcohol Dependency	□ Hepatitis (B or C)	□ Tobacco Habit If stopped, date:_____
□ Artificial Heart valve	□ Epilepsy	□ Kidney Disease	□ Tuberculosis
□ Asthma/ Emphysema	□ Fainting	□ Liver Disease	□ Ulcers/ Colitis/ Crohn's
□ Blood/ Clotting Disorder	□ Glaucoma	□ Mitral Valve Prolapse	□ Anxiety Disorder
□ Cancer: _____	□ Headaches, chronic	□ Neurological Disease	□ NONE
□ Chemotherapy	□ Heart Attack	□ Pacemaker	OTHER:_____
□ Circulatory Problems	□ Heart Disease	□ Rheumatic Fever	_____
□ Cough, persistent	□ Heart Surgery	□ Radiation Treatment	_____
□ Diabetes	□ High Blood Pressure	□ Steroid Treatment	_____
□ Joint Replacement _____	□ HIV/ AIDS	□ Stroke	_____
		□ Thyroid Disorder	

Please list *ALL* prescription, over the counter medications and supplements you are currently taking (If *no medications, please write* ***None***) _____

_____

_____

_____

Have you been advised by a physician to premedicate with antibiotics prior to dental treatment? □ Yes □ No

Have you ever been prescribed a Bisphosphonate class drug (Fosamax, Actonel, Boniva…) used for bone density? □ Yes □ No If yes, for how long?_____

ABOVE INFORMATION IS TRUE: I have read and understand the above, I acknowledge that my questions if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist(s) or any other member of the staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature: _____Date_____