MICHAEL A. COLASANTO D.D.S . **PERIODONTICS**
3801 N. FAIRFAX DR., SUITE 51 N., ARLINGTON, VIRGINIA 22203 TEL.(703)525-7471

Welcome to our office . . .

PERSONAL INFORMATION

Name: Mr / Mrs / Miss / Ms / ____ SSN______-______-______

Required By Insurance Co. Single Married

Spouse or Parent (If child): ____ SSN______-______-_____

Home Address (No P.O.Box.) ____

City_________________________________ State____________________Zip__________________________

Home Tel.________________________ Work Tel.______________________ Cell: ____________________

Email ____

Employer_____________________________________ Occupation____________________________________

Date of Birth_______________Person Responsible for Payment of Account___________________________

Whom May We Thank for Referring You?________________________Name of General Dentist___________

Pharmacy Phone #/Address: ____

EMPLOYER AND DENTAL INSURANCE INFORMATION

Insurance Company Name, Address, Phone No.____

____ I.D. ______________________________

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_______________________________

Employer's Address and Tel#____

Secondary Insurance Co. Name_____________________________________Group #____________________

FINANCIALLY RESPONSIBLE PERSON

(If other than patient)

Name: ___________________________________Relationship to patient:___________________________

Address: ____

Home Tel:____Work Tel:_________________________________

Date of Birth: _______________________________________Soc. Sec. No: ________-__________-_________

DENTAL HISTORY

Reason for Today's Visit? ____

Do you currently have problems with any of the following?

◊ Bad breath
◊ Bleeding
◊ Clicking or popping
◊ Food collection between teeth
◊ Grinding teeth or clenching teeth
◊ Oral sores or growths
◊ Periodontal treatment
◊ Sensitive to cold
◊ Sensitive to hot
◊ Sensitive to sweets
◊ Sensitive when biting
◊ Spontaneous pain

MEDICAL HISTORY

Primary Physician's name ______________________________Date of last visit________

Have you had any serious illnesses or been hospitalized in the past two 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 had an adverse reaction to any of the following medications or substances?

Aspirin
Clindamycin
Codeine
Darvon
Demerol
Erythromycin
Latex
Local Anesthetic
Nitrous Oxide
Ibuprofen
Penicillin
Percocet
Tetracycline
Tylenol
Vicodin
Other

If other, please list: ____

If you have or have had any of the following, Please check:

◊ Anemia
◊ Arthritis, Rheumatism
◊ Artificial Heart valve
◊ Artificial Joints
◊ Asthma
◊ Back Problems
◊ Blood Disease
◊ Blood Transfusion
◊ Cancer
◊ Chemical Dependency
◊ Chemotherapy
◊ Circulatory Problems
◊ Cough, Persistent
◊ Cough up Blood
◊ Diabetes
◊ Epilepsy
◊ Fainting
◊ Glaucoma
◊ Headaches
◊ Heart Murmur
◊ Heart Disease
◊ Hemophilia
◊ High Blood Pressure
◊ HIV Positive
◊ Hepatitis
◊ Kidney Disease
◊ Liver Disease
◊ Mitral Valve Prolapse
◊ Neurological Disease
◊ Pacemaker
◊ Rheumatic fever
◊ Radiation Treatment
◊ Respiratory Disease
◊ Scarlet Fever
◊ Shortness of Breath
◊ Skin Rash
◊ Stroke
◊ Swelling of feet or ankles
◊ Thyroid Disorder
◊ Tobacco Habit
◊ Tonsillitis
◊ Tuberculosis
◊ Ulcer
◊ Anxiety Disorder

Please list any diseases, conditions or problems not checked above________________________

____ ______________________________

Please list all medications you are currently taking ___________________________________

____

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____________________