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?

- ☐ Bleeding gums
- ☐ Difficulty opening mouth/ TMJ pain
- ☐ Food collection between teeth
- ☐ Shifting or movement of teeth
- ☐ Grinding or clenching teeth
- ☐ Sensitive to sweets
- ☐ History of periodontal treatment
- ☐ History of orthodontic treatment
- ☐ Sensitive to hot/cold
- ☐ Sensitive when biting
- ☐ Spontaneous pain

- Have you ever had an injury to your face or jaw? ☐ Yes ☐ No _____
- History of chronic headaches, facial or jaw pain? ☐ 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 _____

- Have you been advised by a physician to premedicate with antibiotics prior to most of your dental appointments and/or dental treatment (due to an artificial valve/ joint replacement/ endocarditis, etc.)? ☐ 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?_____
- Have you or are you currently taking any blood thinning medications? ☐ Yes ☐ No

If yes, list the medication/s _____

(If Female) Are you pregnant? ☐ Yes ☐ No 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
- ☐ Clindamycin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Tylenol
- ☐ NO ALLERGIES
- ☐ Other: Please list: _____

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

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

OTHER:_____

_____

_____

_____

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

_____

_____

_____

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**_____