AMEDEO & COLONNA, LTD.
BERNARD D. COLONNA, D.D.S. KEVIN P. MALONEY, D.M.D

Welcome to Our Office!

Patient's Name: _____ Birthdate: _____

Email: _____ SS #: _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Sex M ☐ F ☐

Home Address: _____
Street City State Zip

Occupation: _____ Employer: _____ Cell Phone: _____

Spouce's Name: _____ Employer: _____ Home Phone: _____

Person Responsible for Payment: _____ Work Phone: _____

Emergency Contact Name & Phone: _____

Name of Dental Insurance: _____ ID #: _____

Group Number: _____ Policy Holder Birthdate: _____

Name of Secondary Insurance: _____ ID #: _____

Group Number: _____ Policy Holder Birthdate: _____

Who Referred You to Our Office: _____

Name of Previous Dentist: _____ Date of Last Visit: _____

Are you allergic to any medications, anesthetics, latex, etc? No ☐ Yes _____

Are you taking any medications that thin the blood (ex: Coumadin)? No ☐ Yes _____

Are taking any medications for osteporosis or bone density loss? No ☐ Yes _____

Please list any other medications you are taking: _____
Use back if needed.

Have you ever been told to premedicate with antibiotics before dental treatment in the past? No ☐ Yes ☐

Have you had an artificial joint (hip, knee, etc.) replacement? No ☐ Yes _____

Have you had a damaged heart valve or an artificial valve? No ☐ Yes _____

Do you smoke? No ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Chewing Tobacco ☐ Approximate # per day _____

MARK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR CURRENTLY HAVE:

☐ Angina / Chest Pain	☐ Drug Addiction / Alcoholism	☐ Hepatitis / Liver Disease	☐ Rheumatic Fever
☐ Asthma	☐ Emphsema	☐ High Blood Preasure	☐ Rheumatoid Arthritis
☐ Bleeding Problems	☐ Epliepsy / Seizures	☐ HIV Positive / AIDS	☐ Sinus Trouble
☐ Cancer / Chemotherapy	☐ Glaucoma	☐ Infective Endocarditis	☐ STD / Herpes
☐ Congenital Heart Lesions	☐ Heart Attack	☐ Kidney Trouble	☐ Stroke
☐ Congestive Heart Disease	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Diabetes	☐ Heart Pacemaker	☐ Pain in Jaw Joints	☐ Tuberculosis

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WOMEN: Are you pregnant or nursing? No ☐ Yes ☐

Taking birth control pills? (Antibiotics may deminish effectiveness) No ☐ Yes ☐

Is there any other medical or dental information that you feel we should know about? _____

_____

Signed: _____ **Date:** _____