COLOMBO DENTAL ASSOCIATES, L.L.P.
FRED J. COLOMBO, D.D.S.
VICTORIA COLOMBO, D.M.D
FRANK LIU, D.D.S.
996 HICKSVILLE ROAD • MASSAPEQUA, NY 11758
(516) 799-1787 • (516) 799-1853 • (516) 799-2623

REGISTRATION AND MEDICAL HISTORY

DATE ____________________

PATIENTS NAME ____________________ SINGLE ____________________

ADDRESS ____________________ MARRIED ____________________

TOWN ____________________ ZIP ____________________ OTHER ____________________

EMAIL ADDRESS ____________________ HOME PHONE ____________________

SS# ____________________ DATE OF BIRTH ____________________ BUS.PHONE ____________________

OCCUPATION ____________________ CELL PHONE ____________________

PATIENT EMPLOYED BY ____________________

BUSINESS ADDRESS ____________________

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED ____________________

____________________ PHONE ____________________

DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES

YES ____________________ NO ____________________

NAME OF COMPANY ____________________ POLICY # ____________________

WHO WILL PAY FOR THIS ACCOUNT *(SIGNATURE PLEASE)* ____________________

WHOM MAY WE THANK FOR REFERRING YOU ____________________

PHYSICIAN'S NAME ____________________ PHONE ____________________

ADDRESS ____________________

PLEASE CIRCLE

HEART PACEMAKER	NO	YES
HEART DISEASE	NO	YES
HEART VALVE REPLACEMENT	NO	YES
ANGINA	NO	YES
RHEUMATIC FEVER	NO	YES
HEART MURMUR	NO	YES
PROLAPSED MITRAL VALVE	NO	YES
ABNORMAL BLOOD PRESSURE	NO	YES
CONGENITAL HEART LESIONS-DEFECTS	NO	YES
STROKE	NO	YES
EPILEPSY/ SEIZURE DISORDER	NO	YES
JAUNDICE	NO	YES
HIV POSITIVE	NO	YES
GONORRHEA	NO	YES
SYPHILLIS	NO	YES
HERPES	NO	YES
X-RAY OR CHEMO-THERAPY	NO	YES
DO YOU SMOKE	NO	YES
DO YOU DRINK ALCOHOLIC BEVERAGES	NO	YES
OFFENSIVE BREATH	NO	YES
DO YOU OR HAVE YOU TAKEN DRUGS	NO	YES
MARIJUANA, COCAINE, HEROIN, CRACK	NO	YES

PROLONGED BLEEDING	NO	YES
BLOOD TRANSFUSION	NO	YES
AIDS	NO	YES
HEPATITIS	NO	YES
DIABETES	NO	YES
ULCERS	NO	YES
HAY FEVER	NO	YES
SINUS PROBLEMS	NO	YES
PERSISTENT COUGH	NO	YES
ASTHMA	NO	YES
EMPHYSEMA	NO	YES
ANEMIA	NO	YES
GLAUCOMA	NO	YES
KIDNEY DISEASE OR DIALYSIS	NO	YES
ANY TRANSPLANTED ORGANS	NO	YES
ANY COMMUNICABLE DISEASES	NO	YES
PAIN IN JAW JOINTS	NO	YES
PIN, ROD, OR ANY FOREIGN OBJECT IMPLANTED IN YOUR BODY	NO	YES
ANYTHING NOT LISTED	NO	YES

IF SO, LIST ____________________

Continued on next page *(OVER)*

HAVE YOU HAD ANY FORM OF CANCER..NO YES

IF SO, LIST ______

ARE YOU ALLERGIC TO ANY MEDICATION..NO YES

IF SO, LIST ______

ARE YOU ALLERGIC TO LOCAL DENTAL ANESTHETICS

(NOVOCAINE, XYLOCAINE, CARBOCAINE, ETC.) ....NO YES

ARE YOU PRESENTLY TAKING ANY MEDICATION ....NO YES

IF SO, LIST ______

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN..................................NO YES

IF SO, LIST REASON ______

DO YOU NORMALLY TAKE LOCAL ANESTHETIC FOR

ROUTINE DENTAL TREATMENT..NO YES

DO YOUR GUMS BLEED EASILY WHEN BRUSHING ....NO YES

WHEN WAS YOUR LAST DENTAL EXAMINATION ______

WHEN DID YOU LAST HAVE FULL MOUTH X-RAYS ______

PURPOSE OF THIS APPOINTMENT ______

______

SMILE EVALUATION

ARE YOU HAPPY WITH YOUR SMILE..NO YES

DO YOU WISH TO DISCUSS ANY COSMETIC DENTISTRY TO IMPROVE

YOUR SMILE AND DENTAL APPEARANCE ....NO YES

FOR WOMEN ONLY

ARE YOU PREGNANT..NO YES

ARE YOU NURSING..NO YES

ARE YOU TAKING BIRTH CONTROL PILLS ....NO YES

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND ALL ANSWERS ARE CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH OR MEDICATION, I WILL INFORM YOU IMMEDIATELY.

______

SIGNATURE OF PATIENT OR GUARDIAN