Distinctive Dental Solutions
Bret A. Bologna, DDS

Learn. Grow. Be Healthy.

11039 BROADWAY SUITE A CROWN POINT, INDIANA 46307 (219) 663-7193

Welcome to Our Practice

PATIENT INFORMATION

Name _____ Check Appropriate Box: ❒ Minor ❒ Single ❒ Married

Social Security # _____ Birth Date _____ Driver's License# _____

Address _____ City _____ State _____ Zip _____

(If listing a P.O. Box as your mailing address, our office is still required to get a home address. Please list both.)

Home Phone _____ Cell Phone _____ Work Phone _____

What is the best number to contact you? (Check one) ❒ Home ❒ Cell ❒ Work Email address: _____

Name of Employer _____

Whom May We Thank for Referring You? _____ Relationship to Patient _____

Emergency Contact Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

What is the best number to contact them? (Check one) ❒ Home ❒ Cell ❒ Work

RESPONSIBLE PARTY (Complete if patient is a minor or requires a legal guardian. Must be present at first appointment.)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Social Security # _____ Birth Date _____ Driver's License# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

What is the best number to contact them? (Check one) ❒ Home ❒ Cell ❒ Work Currently a Patient in our Office? ❒ Yes ❒ No

Employer _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Social Security # _____ Birth Date _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Union or Local # _____

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits, and understand that Bret A. Bologna, D.D.S. assumes no responsibility for the compliance with the requirements my insurance company may impose to receive benefits. I authorize the use of this signature on all insurance submissions.

I agree that I am financially responsible for all fees and charges at the time services are rendered. I agree that I am financially responsible for fees and charges not covered or paid by my insurance company, if any, and that any account not paid at the time services are rendered is subject to a monthly finance charge of 1.5%, plus any costs of collection, including attorney fees. I further agree that any possible insurance coverage/payments are based upon a separate agreement to which Dr. Bret A. Bologna, D.D.S. is not a party and it is my sole responsibility to comply with any and all requirements my insurance company may impose to receive benefits.

Printed name of patient or parent/legal guardian _____ Date _____

Signature of patient or parent/legal guardian _____ Date _____

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Name _____ Today's Date _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental x-rays _____

Have you ever been prescribed an antibiotic previous to dental work? _____ If so, what antibiotic? _____

How often do you floss? _____ How often do you brush? _____

Check (✓) if you have had any of the following:

- ❒ Bad breath
- ❒ Bleeding gums
- ❒ Clicking or popping jaws
- ❒ Food collection between teeth
- ❒ Grinding teeth
- ❒ Loose teeth or broken fillings
- ❒ Periodontal treatment
- ❒ Sores or growths in your mouth
- ❒ Sensitivity to sweets
- ❒ Sensitivity when biting
- ❒ Sensitivity to cold / heat
- ❒ Headaches
- ❒ Jaw Pain
- ❒ Dry Mouth

MEDICAL HISTORY

Primary Physician Information (Name) _____ (Phone #)_____ (Last Visit?)_____

Have you had any serious illness or operations in last ten years? Yes / No If yes, specify _____

(Women) Are you pregnant? Yes / No If yes, due date_____ Nursing? Yes / No Taking birth control pills? Yes / No If yes, which_____

Check (✓) if you have had any of the following in the past 10 years and indicate any specific Physicians for the listed condition in the space provided:

- ❒ Anemia
  - Type _____
- ❒ High Blood Pressure
  - Physician _____
  - Under control? Yes / No
- ❒ Diabetes
  - Physician _____
  - Type _____
  - Under control? Yes / No
- ❒ Hemophilia
  - Physician _____
- ❒ Glaucoma
  - Physician _____
  - Type _____
- ❒ HIV Positive
  - Physician _____
- ❒ Thyroid Problems
  - Physician _____
  - Describe _____
- ❒ Fainting
  - Trigger _____
- ❒ Asthma
  - Inhaler? Yes / No
  - Trigger _____
- ❒ Tuberculosis
  - Physician _____
- ❒ Persistent Cough
- ❒ Respiratory Disease
  - Physician _____
  - Describe _____
- ❒ Shortness of Breath
  - Anything we need to know?_____
  - _____
- ❒ Tobacco Habit
  - Chew / Smoke
  - How much? _____
  - Do you want to quit? Yes / No
- ❒ Arthritis
  - Physician _____
  - Osteoid / Rheumatoid
- ❒ Psychiatric Care
  - Physician _____
- ❒ Artificial Joints
  - Physician _____
  - Which? _____
- ❒ Chemical Dependence
  - Under control? Yes / No
- ❒ Cancer
  - Physician _____
  - Type _____
- ❒ Chemotherapy
  - Approx. Dates_____
- ❒ Radiation
  - Approx. Dates_____
  - Location _____
- ❒ Liver Disease
  - Physician _____
  - Describe _____
- ❒ Hepatitis
  - Physician _____
  - Type _____
- ❒ Stroke
  - Physician _____
- ❒ Kidney Disease
  - Physician_____
  - Describe _____
- ❒ Artificial Heart Valves
  - Physician_____
- ❒ Heart Murmur
- ❒ Mitral Valve Prolapse
  - Regurgitation? Yes / No
  - Physician_____
- ❒ Chest Pain
  - Nitroglycerin? Yes / No
- ❒ Pacemaker
  - Physician_____
- ❒ Back Problems
  - Problems w/positioning? Yes / No
- ❒ Epilepsy
  - Physician_____
  - Type _____
  - Trigger _____

NOTES: _____

Any condition not listed above, please describe: _____

MEDICATIONS

List medications you are currently taking:
(If you need additional room, attach a separate sheet.)

NAME	DOSAGE	X/DAY

ALLERGIES

List of most common allergies:

- Penicillin
- Local Anesthetic (Xylocaine, Septocaine)
- Sulfa
- Codeine
- Aspirin
- Costume Jewelry
- Latex
- Clindamycin
- Barbiturates (Sleeping Pills)
- Other Medications: _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize Bret A. Bologna, D.D.S, P.C. to confer with my physician(s) about pertinent medical/dental considerations in treatment of my case.

Signature of patient or parent/legal guardian _____ Date _____

FUTURE USE:

Signature of patient or parent/legal guardian _____ Date _____

Signature of patient or parent/legal guardian _____ Date _____