MARC A. ROSSOW DDS

To help us meet all your dental health care needs, please fill out this form. (Use ink, not pencil).
All information will be strictly confidential. If you need help feel free to ask!!

PATIENT INFORMATION:

Today's Date _____

Name _____ Birth date _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State ____ Zip _____

Patient's SS# _____ Circle One: Minor Single Married

Patient's Employer (if any) _____ Work Phone _____

Employer's Address _____ City _____ State ____ Zip _____

Spouse's (or Parent's) Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School or College_____ City _____ State ____

Whom May We Thank For Referring You ? _____

Emergency Contact _____ Phone _____ Relationship _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:

(If patient is responsible for payment skip this section)

Name _____ Relationship to patient _____

Address _____ City _____ State ____ Zip _____

Birth date _____ SS# _____ Home Phone _____

Employer _____ Work Phone _____

Is this Person currently a Patient in our office? Yes No (circle one)

(sheet 1, continue on sheet 2)

DENTAL INSURANCE INFORMATION (IF ANY) :

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# _____

Employer _____ Work Phone _____

Employer's Address _____ City _____ State ____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes No (circle one)
If Yes, please complete the following section:

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# _____

Employer _____ Work Phone _____

Employer's Address _____ City _____ State ____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

PATIENT MEDICAL HISTORY:

GENERAL INFORMATION:

Are you currently under the care of a physician? Yes No (circle one)

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you ever had any serious illness or operation Yes No If Yes please list:

_____

_____

List ALL medications you are taking (prescription and over the counter). Attach separate sheet if needed.

_____

_____

_____

_____

(sheet 2, continue on sheet 3)

Do you have allergies, or adverse reactions to any of the following?:

Y N Penicillin or other antibiotics
Y N Aspirin, Tylenol, or Ibuprofen
Y N Codeine or other narcotics
Y N Local anesthetics ("Novocaine", etc.)
Y N Latex Products
Y N Jewelry or metal alloys
Y N Other Allergies? (Please List) _____

These questions are for women only:

Y N Are you pregnant, or think you may be?
Y N Are you nursing?
Y N Are you taking birth control pills?

Do you have, or have you had any of the following?:

Y N Heart murmur, or Congenital Heart issues (including Mitral Valve Prolapse)
Y N Epilepsy, or convulsions
Y N Lung disorders (Tuberculosis, Asthma or Pneumonia)
Y N Cardiovascular, or Heart disease
Y N Heart attack (if yes, date: _____)
Y N Diabetes
Y N High, or Low blood pressure
Y N Kidney Disease (including Dialysis)
Y N Thyroid disorder
Y N Stroke (if yes, date: _____)
Y N History of Cancer (including Radiation Therapy) (if yes, date: _____)
Y N Coronary insufficiency, or Occlusion (including bypass surgery or stents) (if yes, date: ____)
Y N Psychiatric Treatment (nerves, depression, or anxiety)
Y N Angina, or chest pain
Y N Pacemaker
Y N Stomach problems (including ulcers)
Y N History of Sinus problems
Y N History of Rheumatic Fever
Y N Recent weight loss or gain
Y N Joint replacement, or implant
Y N Arthritis
Y N Bleeding disorder (Hemophilia, Anemia, or Sickle Cell)
Y N Immune suppressed condition (chemotherapy, organ transplant, or HIV/AIDS)
(If yes, please specify _____)
Y N Liver Disease (Hepatitis, or Jaundice)

Do you have any other disease, problem, or condition that we should be aware of? Y N
If so, please specify _____
_____

Do you use any of the following?:

Y N Tobacco, if Yes circle type(s): cigarettes cigars pipe smokeless (chewing tobacco)
Y N Alcohol
Y N Recreational Drugs

(sheet 3, continue on sheet 4)

PATIENT DENTAL HISTORY:

Y N Have you had any previous problems with dental treatments? (For example, difficulty getting numb, bleeding, rior negative experience with a dentist, etc.)
If so, please list _____

Y N Is there anything about the appearance of your teeth that you would like to change?
If so, please list _____

Y N Are your teeth sensitive to hot, cold, or sweets?

Y N Do you have pain in any of your teeth?

Y N Are any of your teeth loose?

Y N Do you feel you have bad breath?

Y N Do you clench or grind your teeth?

Y N Any history of Orthodontic work?

Y N Have you ever had problems with your jaw joints? (pain, difficulty opening, closing, chewing)

Y N Any history of head, jaw or neck injuries?

AUTHORIZATION AND RELEASE:

I certify that the questions on this form have been accurately answered to the best of my knowledge.

I understand that providing incorrect information could be dangerous to my health.

I authorize the dentist to release information including: the diagnosis, records of any treatment, or details of any examination rendered to me, or my dependent child, during the period of dental care to other third party payers or health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for full payment of all services rendered on my, or my dependents, behalf; even if not covered by insurance.

I will be responsible for all fees incurred should collection of my account become necessary.

X _____
Signature of patient or parent, if patient is a minor.