

**\* Patient Information**

<b>Patient Name</b> Last, First, Middle	<b>Preferred Name</b>	<b>Date of Birth</b>	<b>Marital Status</b>	
<b>Social Security Number</b>	<b>Sex</b>	<b>Employer</b>	<b>Occupation</b>	<b>Referred By</b>
<b>Residence Address</b> Number/Street	City	State	ZIP	<b>Email</b>
<b>Home Phone</b>	<b>Cell Phone</b>	<b>Spouse's Name</b>	<b>Spouse's Employer</b>	

**\* Insurance Information**

<b>Insurance Company</b>	<b>Name of Policy Holder</b>	<b>Group Number</b>	<b>Member ID</b>	<b>Relationship to Policy Holder</b>
<b>DOB of Policy Holder</b>	<b>SSN of Policy Holder</b>	<b>Emergency Contact</b>	<b>Telephone</b>	<b>Relationship</b>

**\* Patient Preferences**

\_\_\_\_\_  
**Appointment Reminder Preference** (call, text, email)

\_\_\_\_\_  
**Credit Card Number**

\_\_\_\_\_  
**Exp. Date**      **Code**      **Billing ZIP**

**PAYMENT PREFERENCE**

- Pay at time of service
- Credit card on file
- Email
- Mail
- Pay upfront in cash/check and save 5% for services over \$500

I understand that I (or guardian signed below) have the primary duty to pay my doctor for services even though a portion of the fees may be payable or reimbursable by an insurance company or other third party payer.

I understand that the determination of the dental care to be given to me by my doctor and the fees to compensate for that care are matters between my doctor and myself. These fees are due at the time that services are rendered; any balance due longer than sixty (60) days from the date of service will be assessed at the rate of 1.5% per month as a service charge.

I hereby authorize Noah H. Rosen, DMD, to release my insurance company or other third party payer or its representative any information including the diagnosis and the records of any treatment or examination rendered to me.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Signature of Guardian (if necessary)**

**\* Medical & Dental History**

**What made you choose our office?**      **How would you describe your general medical health?**      **Do you have any specific concerns?**

**Have you ever been hospitalized or had an operation?** (please explain)      **Have you been told you snore/diagnosed with sleep apnea?** (Y/N)

**Are you currently pregnant?** (if so, how far along?)      **Do you use tobacco?** (if yes, how much?)      **Name of General Physician**      **Phone Number**

**Please list any birth control, prescription medications, supplements, vitamins, etc. you are currently taking**

**ARE YOU ALLERGIC TO THE FOLLOWING?**

- |                                  |   |                                      |                                       |
|----------------------------------|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acrylic | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Metals      | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Penicillin  | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex              | <input type="checkbox"/> Sulfa Drugs |                                       |

**HAVE YOU HAD ANY OF THE FOLLOWING?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia               | <input type="checkbox"/> Colitis                                  | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Allergies                                  | <input type="checkbox"/> Congenital Heart Defect                  | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Anemia                                     | <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Arthritis/Gout                             | <input type="checkbox"/> Emphysema                                | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Artificial Joint                           | <input type="checkbox"/> Epilepsy                                 | <input type="checkbox"/> Skin Disorders          |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Heart Disease/Pacemaker/Artificial Valve | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Cancer/Chemotherapy-Radiation Therapy      | <input type="checkbox"/> Hepatitis                                | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Cardiovascular Disease/Stroke/Heart Attack | <input type="checkbox"/> High Blood Pressure/Low Blood Pressure   | <input type="checkbox"/> Other _____             |

**Approx. date of last dental visit**      **What was done?**      **Do you grind your teeth?** (Y/N)      **How often do you floss?**

**How do you rate your smile on a scale of 1-10?** (10 = highest)      **If not satisfied, would you like to discuss options for improvement?** (Y/N)

**PLEASE SELECT ANY THAT YOU HAVE A PROBLEM WITH:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Teeth sensitive to hot  | <input type="checkbox"/> Teeth sensitive to sweets  | <input type="checkbox"/> Receding gums | <input type="checkbox"/> Bleeding gums              |
| <input type="checkbox"/> Teeth sensitive to cold | <input type="checkbox"/> Teeth sensitive to chewing | <input type="checkbox"/> Sore gums     | <input type="checkbox"/> Frequent cold/canker sores |

**IF LOOKING FOR IMPROVEMENT, PLEASE SELECT WHAT YOU WOULD BE INTERESTED IN DISCUSSING:**

- |                                     |                                 |  |
|-------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Color      | <input type="checkbox"/> Spaces | <input type="checkbox"/> Crooked Teeth |
| <input type="checkbox"/> Shape/Size | <input type="checkbox"/> Chips  | <input type="checkbox"/> Other         |