ROSEN DENTAL

2845 N Sheridan Road, Suite #706
Chicago, IL 60657 · (773) 248-6140

Patient Information

Patient Name Last, First, Middle | **Preferred Name** | **Date of Birth** | **Sex**

Marital Status | **Social Security Number** | **Employer** | **Occupation** | **Referred By**

Residence Address Number/Street | City | State | ZIP | **Email**

Spouse's Name | **Spouse's Employer** | **Home Phone** | **Cell Phone**

Referred By | **Emergency Contact** | **Phone** | **Relationship**

Insurance Information

Insurance Company | **Name of Policy Holder** | **Group Number** | **Member ID**

DOB of Policy Holder | **SSN of Policy Holder** | **Relationship to Policy Holder**

Patient Preferences

Appointment Reminder Preferences (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)**

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Insurance Information

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?

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Other _____

HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ Abnormal Bleeding/Hemophilia
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Cancer/Chemotherapy-Radiation Therapy
- ☐ Cardiovascular Disease/Stroke/Heart Attack
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease/Pacemaker/Artificial Valve
- ☐ Hepatitis
- ☐ High Blood Pressure/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Osteoporosis/Osteopenia
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Disorders
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ 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:

- ☐ Teeth sensitive to hot
- ☐ Teeth sensitive to cold
- ☐ Teeth sensitive to sweets
- ☐ Teeth sensitive to chewing
- ☐ Receding gums
- ☐ Sore gums
- ☐ Bleeding gums
- ☐ Frequent cold/canker sores

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

- ☐ Color
- ☐ Shape/Size
- ☐ Spaces
- ☐ Chips
- ☐ Crooked Teeth
- ☐ Other