



DAVID ROSENBAUM, DDS
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DECATUR, TEXAS 76234
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Patient Information (Confidential)

Name _____ Date _____

SS# _____ Birthdate _____

Home phone # _____ Cell # _____ Work # _____

Address _____ City _____

State _____ Zip _____ Email _____

Check appropriate: Minor Single Married Divorced

If student, name of school: _____ Full time or part time: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____

If Minor-Parent Information

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ State _____ Zip Code _____

Email _____ DL # _____

Birthdate _____ SS # _____

Is this person currently a patient in our office? yes no

Insurance Information

Name of insured _____

Birthdate _____ SS # _____ PH # _____

Name of Employer _____

Insurance Company _____

Group # _____ Insured ID # _____ Insurance PH # _____

Insurance Company Address _____

Do you have secondary insurance? yes no

Patient Medical History

Physician _____ Office Phone _____

1. Are you under medical treatment right now?
2. Have you ever been hospitalized for any surgical operation or illness within the last 5 years?
3. Are you taking any medications including non-prescription medicine?
4. Have you ever taken Fen-Phen/Redux?
5. Do you use tobacco?
6. Do you use controlled substances?
7. Are you wearing contact lenses?

8. Are you allergic to or have any reactions to the following?

Aspirin	Penicillin or any other antibiotics
Barbiturates	Sedatives
Iodine	Sulfa Drugs
Latex Rubber	Other _____
Local anesthetics	_____
Metals (<i>Nickel, Mercury, etc.</i>)	

9. Do you have or have you experienced any of the following? (check the box if yes)

AIDS/HIV	Glaucoma	Radiation Therapy
Anemia	Hay fever/Allergies	Recent Weight Loss
Angina	Heart Attack	Respiratory Problems
Arthritis	Heart Disease	Rheumatic Fever
Asthma	Heart Murmur	Sexually Transmitted Diseases
Cancer	Heart Trouble	Stomach Trouble/Ulcers
Cardiac Pacemaker	Hepatitis/Jaundice	Stroke
Chest Pains	High Blood Pressure	Swollen Ankles
Diabetes	Joint Replacement	Thyroid Problem
Easily Winded	Kidney Diseases	Tuberculosis
Emphysema	Leukemia	Other _____
Epilepsy/Convulsions	Liver Disease	_____
Fainting/Seizures	Low blood pressure	
Frequently Tired	Mitral Valve Prolapse	

10. Are you currently experiencing any of the following? (check the box if yes)

Nursing	Taking oral contraceptives
Pregnant	Trying to get pregnant

Patient Dental History

Name of Previous Dentist and Location _____ Date of last exam _____

	Yes	NO		Yes	NO
Do your gums bleed while brushing?			Do you have frequent headaches?		
Are your teeth sensitive to hot or cold?			Do you clench or grind your teeth?		
Are your teeth sensitive to sweet or sour?			Do you bite your lips or cheeks?		
Do you feel pain in any of your teeth?			Have you ever had a difficult extraction?		
Do you have any sores or lumps in or near the mouth?			Have you had prolonged bleeding following extractions?		
Have you had any head, neck, or jaw injuries?			Have you had orthodontics?		
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials?		
Clicking?			Do you like your smile?		
Difficulty opening, closing, or chewing?					

Please list all medications, vitamins, and supplements you are currently taking:

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 payment of all services rendered on my behalf or my dependents.**

X _____
Signature of patient (or patient/guardian of minor)