Rosenbaum DENTAL
DAVID ROSENBAUM, DDS
2201 S. HWY 51, SUITE 300
DECATUR, TEXAS 76234
(940) 626-0003

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
- ☐ Barbiturates
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local anesthetics
- ☐ Metals *(Nickel, Mercury, etc.)*
- ☐ Penicillin or any other antibiotics
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Other_____

_____

9. Do you have or have you experienced any of the following? *(check boxes below if yes.) Check here if no to all* ☐

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

_____

10. Are you currently experiencing any of the following? *(check boxes below if yes.) Check here if no to all* ☐

- ☐ Nursing
- ☐ Pregnant
- ☐ Taking oral contraceptives
- ☐ 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?	☐	☐
			Do you like your smile?	☐	☐
Clicking?	☐	☐			
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)