

The DENTAL Suite

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION		
Date _____	Home phone _____	Cell phone _____
Name _____		SS/HIC/Patient ID _____
Address _____		Email _____
City _____		State _____ Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____ Birthdate _____	<input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> separated
Patient Employer/School _____		Occupation _____
In case of emergency who should be notified? _____ Phone _____		

Referral Source _____

INSURANCE INFORMATION		
Person responsible to account _____		
Relation to patient _____	Birthdate _____	Soc. Sec. # _____
Address (if diff. from patient) _____		Phone # _____
City _____		State _____ Zip _____
Insurance Company _____		
Contract # _____	Group # _____	Subscriber # _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last X-rays _____

Address _____

Check if you have problems with any of the following:

bad breath grinding teeth sensitivity to heat
 bleeding gums loose teeth/broken fillings sensitivity to sweets
 clicking or popping jaw periodontal treatment sensitivity when biting
 food collection between teeth sensitivity to cold sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as 'len-phen'? These include combinations of Ionimin, Adipex, Fastin, Pondimin and Redux.

yes no

Have you had any serious illness or operation? yes no

If yes, describe _____

Have you ever had a blood transfusion yes no

If yes, give approximate dates _____

Are you pregnant? yes no Nursing? yes no Taking birth control pills? yes no

Check if you have or have had any of the following:

anemia cortisone treatment hepatitis Scarlett fever
 arthritis, rheumatism cough, persistant high blood pressure shortness of breath
 artificial heart valves cough up blood HIV/AIDS skin rash
 artificial joints diabetes jaw pain stroke
 asthma epilepsy kidney disease swelling of feet or ankles
 back problems fainting liver disease thyroid problems
 blood disease glaucoma mitral valve prolapse tobacco habit
 cancer headaches pacemaker tonsillitus
 chemical dependency heart murmur radiation treatment tuberculosis
 chemotherapy heart problems respiratory disease ulcer
 circulatory problems hemophilia rheumatic fever venereal disease

Medications you are currently taking: _____

Allergies: _____

AUTHORIZATION

I certify that I, and/or my dependant(s) have insurance coverage with _____ (name of insurance company) and assign directly to Dr.Rostker all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Patient, Guardian, or Personal Representative

Date

Print name of patient, guardian, or personal representative

Relationship to patient