PATIENT HEALTH HISTORY INITIAL VISIT

ROTHFIELD DENTAL ASSOCIATES

DATE _____

NAME _____

STATUS Single

ADDRESS _____ HOME PHONE _____

CITY _____ STATE __ ZIP ____

EMPLOYER _____ WORK PHONE _____

WORK ADDRESS _____

CITY _____ STATE __ ZIP ____

SOCIAL SECURITY NO. _____ EMAIL _____

BIRTH DATE _____ SEX Female

SPOUSE _____ SPOUSES'S S.S.# _____

DENTAL INSURANCE:

1. _____ INSURED'S NAME

2. _____ INSURED'S NAME

WHO WILL PAY FOR THIS ACCOUNT? _____

REFERRED BY _____

PHYSICIAN NAME _____

PHYSICIAN ADDRESS _____

PHYSICIAN PHONE _____

REASON FOR DENTAL VISIT _____

IF UNDER 18:

1. PARENT OR GUARDIAN _____

2. MOTHER'S BIRTH DATE _____ FATHER'S BIRTH DATE _____

HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN OUR OFFICE?

No IF YES, WHO? _____

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE:

1. Astma, hay fever, sinusitis, or other allergies	No
2. Allergy to pencillin, asprin, local or general anesthetic, or other drugs; specify: _____	No
3. Blood pressure or heart problems	No
4. Rheumatic fever or heart murmur	No
5. A pacemaker or open heart surgery	No
6. Diabetes, liver, kidney, thyroid, or lung problems	No
7. Ulcers or stomach problems	No
8. Hepatitis or Jaundice	No
9. Epilepsy or nervous disorders	No
10. Bleeding or clotting disorders	No
11. Arthritis	No
12. Venereal Disease, Herpes	No
13. Acquired Immune Deficiency Syndrome (AIDS)	No
14. Any other illness	No
15. Do any wounds heal slowly or present complications?	No
16. Are you presently taking any medicine? Specify: _____	No
17. Are you presently under care of a physician?	No
18. When was your last physical exam?	No
19. Have you ever been hospitalized?	No
20. Have you had X-ray treatments or chemotherapy?	No
21. Are you presently on a diet?	No
22. Women - Are you pregnant?	No

_____ _____

PATIENT SIGNATURE DATE DOCTOR SIGNATURE

Please Complete reverse Side

PATIENT DENTAL HISTORY

ROTHFIELD DENTAL ASSOCIATES

1. When was your last dental exam?	No
2. When was your last full mouth X-ray taken? Where? _____	No
3. Have you had trouble from previous dental care?	No
4. Do you have pain in your jaw or near your ears?	No
5. Do you have any unhealed injuries or inflamed areas in or around your mouth?	No
6. Have you experienced any growths or sore spots in your mouth?	No
7. Does any part of your mouth hurt when clenched?	No
8. Have you ever had Novacaine or other local anesthetic?	No
9. Have you ever had any reaction or allergic symptoms to Novacaine, local or general ansthetics?	No
10. Have you ever had any difficult extractions in the past?	No
11. Have you ever had prolonged bleeding following extractions in the past?	No
12. Do your gums bleed?	No
13. Do you have a bad taste in your mouth, or mouth odor?	No
14. Have you ever had instructions on the care of your gums?	No
15. Do you chew on only one side of your mouth? If so, why? _____	No
16. Do you habitually clench or grind your teeth during the night or day?	No
17. Is any part of your mouth sensitive to pressures or irritations (hot, cold, or sweet?)	No

Is there any other problem you would like to discuss with the doctor? _____

_____

_____

_____

_____

ARE YOU IN PAIN? No

WHEN WAS YOUR LAST DENTAL VISIT? _____

DO YOU HAVE INSURANCE? No

WHEN WAS YOUR LAST SET OF X-RAYS TAKEN? _____

INSURANCE DETAILS

NAME OF POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____

ID NUMBER _____ TYPE/NAME OF INSURANCE COMPANY _____

GROUP NUMBER _____

CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photography, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge maybe added to any overdue balance. I also assign all Insurance benefits to the Doctor.

_____ _____

PATIENT SIGNATURE (or Parent of Child) DATE INSURED'S SIGNATURE

Please Complete reverse Side