Implant Cosmetic
DENTISTRY
Dr. Joseph M. Rosenwald

Welcome

## Patient Information

Full Name: _____Preferred_____
☐Mr. ☐Mrs. ☐Ms. ☐Minor ☐Dr.
Date of Birth _____SS# _____Driver's License State & #_____
Address_____City/State_____Zip_____
Home Phone_____ Work Phone _____Cell Phone_____
Email Address _____What is the best way to contact you?_____
Employer_____Address_____
City/State_____Zip_____
If Patient Is a Full-time Student, Name of School_____City/State_____
Relative Not Living With You to Contact in Case of an Emergency_____
Complete Address_____
Relationship to Patient_____ Phone_____
Whom May We Thank For Referring You? _____

## Primary Insurance

**Policy Holder _____Relationship to Patient _____Date of Birth_____**
SS# _____Insurance Company _____Group #_____

## Secondary Insurance

**Policy Holder _____Relationship to Patient _____Date of Birth_____**
SS# _____Insurance Company _____Group #_____

## Medical Information

| Yes | No | Don't Know | |
|---|---|---|---|
| | | | **If yes to any of the 3 items below STOP and return this form to the receptionist.** |
| ☐ | ☐ | ☐ | Active Tuberculosis |
| ☐ | ☐ | ☐ | Persistent cough greater than a 3 week duration |
| ☐ | ☐ | ☐ | Cough that produces blood |
| ☐ | ☐ | ☐ | Are you in good health? |
| ☐ | ☐ | ☐ | Has there been any change in your general health within the past year? |
| ☐ | ☐ | ☐ | Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____ _____Physician _____Phone_____ |
| ☐ | ☐ | ☐ | Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?_____ |
| ☐ | ☐ | ☐ | Are you taking or have you recently taken any medicine(s) including non-prescription medicine(s)? If so, what are you taking? Prescribed_____ Over the counter_____ Natural or herbal preparations_____ |
| ☐ | ☐ | ☐ | Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)? |
| ☐ | ☐ | ☐ | Do you drink alcoholic beverages? If yes, how often?_____ |
| ☐ | ☐ | ☐ | Are you alcohol and/or drug dependent? If so, have you received treatment? Yes ☐ No ☐ |
| ☐ | ☐ | ☐ | Do you use drugs or other substances for recreational purposes? If yes, please list_____ _____Frequency of use _____Number of years of recreational drug use_____ |
| ☐ | ☐ | ☐ | Do you use tobacco (smoking, snuff, chew)? |
| ☐ | ☐ | ☐ | Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? _____ |
| ☐ | ☐ | ☐ | Have you had any complications or difficulties with your prosthetic joint? |
| ☐ | ☐ | ☐ | Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and what dose? _____Physician name or Dentist _____Phone_____ |

**Please Continue on Following Page**

| Yes | No | Don't Know | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Abnormal bleeding |
| ☐ | ☐ | ☐ | AIDS/HIV infection |
| ☐ | ☐ | ☐ | Anemia |
| ☐ | ☐ | ☐ | Arthritis |
| ☐ | ☐ | ☐ | Asthma |
| ☐ | ☐ | ☐ | Cancer/chemotherapy /radiation treatment |
| ☐ | ☐ | ☐ | Cardiovascular disease. If yes, specify bellow: |
| | | | O Angina |
| | | | O Heart attack |
| | | | O Heart murmur |
| | | | O High blood pressure |
| | | | O Mitral valve prolapse |
| | | | O Pace maker |
| | | | O Other_____ |
| ☐ | ☐ | ☐ | Chest pain upon exertion |
| ☐ | ☐ | ☐ | Chronic pain |
| ☐ | ☐ | ☐ | Disease, drug, or radiation-induced immunosupression |

| Yes | No | Don't Know | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Diabetes. If yes, specify: |
| | | | O Type I (insulin dependant) |
| | | | O Type II |
| ☐ | ☐ | ☐ | Dry mouth |
| ☐ | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | ☐ | Fainting spells or seizures |
| ☐ | ☐ | ☐ | Hemophilia |
| ☐ | ☐ | ☐ | Hepatitis, jaundice or liver disease |
| ☐ | ☐ | ☐ | Recurrent infections indicate type of infection _____ |
| ☐ | ☐ | ☐ | Kidney problems |
| ☐ | ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | ☐ | Mental health disorders If yes, specify below: _____ |
| ☐ | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | ☐ | Persistent swollen glands in neck |

| Yes | No | Don't Know | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Respiratory problems. Specify: |
| | | | O Emphysema |
| | | | O Bronchitis, etc. |
| ☐ | ☐ | ☐ | Sexually transmitted disease |
| ☐ | ☐ | ☐ | Sinus trouble |
| ☐ | ☐ | ☐ | Sores or ulcers in the mouth |
| ☐ | ☐ | ☐ | Stroke |
| ☐ | ☐ | ☐ | Systemic lupus erythematosus |
| ☐ | ☐ | ☐ | Thyroid problems |
| ☐ | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | ☐ | Ulcers |
| ☐ | ☐ | ☐ | Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:_____ |

_____

_____

## Allergies

Are you allergic to or have you had a reaction to any of the following:

| Yes | No | Don't Know | | Yes | No | Don't Know | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Local anesthetics | ☐ | ☐ | ☐ | Latex |
| ☐ | ☐ | ☐ | Aspirin | ☐ | ☐ | ☐ | Iodine |
| ☐ | ☐ | ☐ | Penicillin or other antibiotics | ☐ | ☐ | ☐ | Hay fever / seasonal |
| ☐ | ☐ | ☐ | Barbiturates, sedatives, or sleeping pills | ☐ | ☐ | ☐ | Sulfa drugs |
| ☐ | ☐ | ☐ | Codeine or other narcotics | ☐ | ☐ | ☐ | Other_____ |

## Women Only

| | | | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Are you pregnant? |
| ☐ | ☐ | ☐ | Nursing? |
| ☐ | ☐ | ☐ | Taking birth control pills? |

## Dental Information

| Yes | No | Don't Know | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Do your gums bleed when you brush? |
| ☐ | ☐ | ☐ | Are your teeth sensitive to cold, hot, sweets or pressure? |
| ☐ | ☐ | ☐ | Have you had any periodontal (gum) treatments? |
| ☐ | ☐ | ☐ | Have you ever had orthodontic (braces) treatment? |
| ☐ | ☐ | ☐ | Do you have headaches, earaches or neck pains? |
| ☐ | ☐ | ☐ | Do you wear removable dental appliances? |
| ☐ | ☐ | ☐ | Have you had a serious/difficult problem associated with any previous dental treatment? If so explain_____ |

_____

_____

How would you describe your current dental problem? _____

Date of your last dental exam _____What was done at that time ?_____

How do you feel about the appearance of your teeth? _____

**Please Continue on Following Page**

## Authorization and Release

I certify that I have read and understand the previous pages. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of these forms. I authorize the dentist to release any information including the diagnosis, photographs, and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners.

## Financial Policy

I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.
If my account becomes assigned to a collection agency, I agree to pay 25% of collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance of over 30 days will be assessed a 1.5 % late charge per month on the unpaid monthly balance.

## Appointments

I understand that a broken appointment fee of $50 per hour is charged to an account when an appointment is broken with less than 24 hours notice. If I find that I cannot keep my scheduled appointment, I will give 24 hour notice so that my doctor may accommodate other patients.

## My signature acknowledges that:

***The questions have been answered truthfully and completely.***
***Photographs of me may be used for educational purposes as stated above.***
***I understand the office policy with keeping appointments, and***
***I understand and will comply with the office Financial Policy.***

Signature of Patient / Legal Guardian Date

Signature of Dentist Date