Welcome

Scott J. Rosen DMD, LLC

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 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 _____
Last First MI

Address _____ E-mail_____

City_____ State_____ Zip_____

Age_____ Birthday_____

Please Circle Status: Married Widowed Single

Sex Male/Female Minor Separated Divorced

Occupation/School _____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____Phone_____

Insurance Information

Primary Insurance

Insured Name_____

Birthdate _____Relationship to Patient_____

Address (if different from patients) _____

Insured Employer_____ Occupation_____

Insurance company_____

ID # / SS#_____ Group #_____

Additional Insurance

Insured Name_____

Birthdate _____ Relationship to Patient_____

Address (if different from patients) _____

Insured Employer_____ Occupation_____

Insurance company_____

ID # / SS#_____ Group #_____

Dental History

Reason for Today's Visit _____ Date of Last Dental Care_____
Former Dentist_____ Date of Last X-rays_____
Address_____
Circle if you have had any problems with any of the following:
Bad Breath Grinding Teeth Bleeding Gums Sensitivity when Biting
Loose Teeth Broken Fillings Sensitivity to Sweets Sensitivity to Cold
Clicking or Popping Jaw Food Collection Between teeth Sensitivity to Hot
Periodontal Treatment Sores or growths in Your Mouth
How often do you floss? _____ How often do you brush? _____

Medical History

Physicians Name _____ Date of Last Visit_____
Have you ever taken any group of drugs referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine) Yes/No
Have you had any serious illness or operations? Yes/No
If yes, describe_____
Have you ever had a blood transfusion? Yes/No If Yes, Give Dates_____
(Women) Are you pregnant? Yes/No Nursing? Yes/No
Taking birth control pills? Yes/No

CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Anemia	Cortisone Treatments	Hepatitis	Scarlet Fever
Arthritis,Rheumatism	Cough,Presistent	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 the Feet
Back Problems	Fainting	Liver Disease	Thyroid Problems
Blood Disease	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Cancer	Headaches	Pacemaker	Tonsillitis
Chemical Dependency	Heart Murmur	Radiation treatment	Tuberculosis
Chemotherapy	Heart Problems	Respiratory Disease	Ulcer
Circulatory Problems	Hemophilia	Rheumatic Fever	Venereal Disease

List medications that you are currently taking: **Allergies:**

_____ _____
_____ _____
_____ _____

Authorization

I certify that I, and/or my dependant (s), have coverage with _____ and
Name of Insurance Company(ies)
assign directly to Scott J. Rosen DMD,LLC 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 my signature on all insurance submissions. Scott J. Rosen may use my health care information and may disclose such information to the above named Insurance Company(ies) for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relative services.

_____ _____ _____
Signature of Patient or Guardian Please print name of patient or guardian Date

Payment is due in full the time of service unless prior arrangements have been made.