

Welcome to Rosewood Dental Care

We are complimented that you have selected us to provide dental care for you and your family. Please print and fill out all 4 pages, and sign the Consent For Treatment on Page 2 and the Medical History Form on Page 3.

PATIENT INFORMATION

Patient Name: _____ Date: _____

If Child, Parent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How Long at this address: _____

Home Phone: _____ Cell Phone _____

Email: _____

Birthdate: _____ Social Security Number: _____

Spouse Name: _____

Email: _____

Birthdate: _____ Social Security Number: _____

Cell Phone _____

RESPONSIBLE PARTY/BILLING INFORMATION

Responsible Party Name: _____

Relationship to patient: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone _____

Email: _____

Birthdate: _____ Social Security Number: _____

Employer: _____ Occupation: _____ Time here: _____

Spouse Name: _____ Cell Phone: _____

Email: _____

Birthdate: _____ Social Security Number: _____

DENTAL INSURANCE, 1ST COVERAGE

Employee Name: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____

Employer: _____

Insurance Company Name: _____

Insurance Company Phone Number: _____

Subscriber ID Number: _____ Group Number: _____

DENTAL INSURANCE, 2nd COVERAGE

Employee Name: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____

Employer: _____

Insurance Company Name: _____

Insurance Company Phone Number: _____

Subscriber ID Number: _____ Group Number: _____

Patient Name: _____ **Date:** _____

CONSENT FOR TREATMENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities of health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information.

Patient's or Guardian's signature: _____ **Date:** _____

Patient Name: _____ Date: _____

MEDICAL HISTORY

Who is your primary care physician? _____ Phone: _____

Date of last physical: _____

Have you been hospitalized under a physician's care in the last two years? Yes No

If so, why? _____

Please list all medications/drugs you are taking:

Have you ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic.)

- | | | | | |
|--|------------------------------------|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Novocaine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Valium | <input type="checkbox"/> Xylocaine | | | |

Others: _____

Have you ever had any of the following? (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Problem or Anemia | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Frequent Thirst | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV-AIDS-ARC | <input type="checkbox"/> Heart Attack or Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Heart Valve or Pacemaker |
| <input type="checkbox"/> Hepatitis (A) | <input type="checkbox"/> Hepatitis (B) | <input type="checkbox"/> Hepatitis (C) |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor or Growth | <input type="checkbox"/> Ulcers or G.I. Problems |
| <input type="checkbox"/> Use Tobacco | <input type="checkbox"/> X-ray/Chemotherapy | |

Have you ever been given antibiotics before dental treatment?

Yes No

Have you recently consumed alcohol?

Yes No

Have you recently used recreational drugs?

Yes No

Recreational use combined with local anesthesia may cause a life-threatening emergency.

Do you take or have you ever taken bisphosphonate therapy medications (commonly used to treat osteoporosis)?

Yes No

Do you have any condition or problem not listed which we should know about? Please explain:

I certify that the above information is complete and accurate.

Patient's or Guardian's signature: _____ Date: _____

Doctor's signature: _____ Date: _____

Patient Name: _____ Date: _____

DENTAL HISTORY

What are your present dental concerns? _____

When was your last dental visit? _____ Dental x-rays? _____

When was your last cleaning? _____

Have you avoided regular dental care?

Yes No

Why? _____

Do you feel you have active decay?

Yes No

Do you experience frequent bad breath?

Yes No

Do you feel you have gum disease?

Yes No

Have you ever had gum treatments?

Yes No

How often do you brush? _____

Floss? _____

Use other aids? _____

Are you happy with the appearance of your teeth?

Yes No

Would you like your teeth to be whiter?

Yes No

What are your dental expectations? _____

Name of previous dentist: _____

City: _____ State: _____

Have you lost any teeth or have any teeth been removed? Yes No

Why? _____

Have they been replaced? Yes No

Replaced by a fixed bridge? Yes No Age?

Replaced by a removable bridge? Yes No Age?

Replaced by dentures? Yes No Age?

Replaced by a dental implant? Yes No Age?

Are you unhappy with the replacement? Yes No

If yes, explain. _____

Would you like to know about permanent replacements? Yes No

Have you ever had any problems or complications with previous dental treatment?

Yes No

If yes, explain. _____

Do you clench or grind your teeth? Yes No

Does your jaw click or pop? Yes No

Have you experienced any pain or soreness in the muscles of your face or around your ear?

Yes No

Do you have frequent headaches, neck aches or shoulder aches?

Yes No

Does food get caught in your teeth? Yes No

Are any of your teeth sensitive to:

Hot Cold Sweets Pressure

Do your gums bleed or hurt? Yes No

If yes, when?

Do you experience dry mouth? Yes No

Have you had any orthodontic work done? Yes No

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

Do you have any specific questions or concerns? _____