ROSEN ✶ DENTAL

PATIENT INFORMATION

Patient Name Last	First	Middle	Date of Birth	Marital Status

Social Security Number	Sex	Employer	Occupation	Referred By

Residence Address Number/Street	City	State	ZIP	Email

Home Phone	Cell Phone	Spouse's Name	Spouse's Employer

INSURANCE INFORMATION

Insurance Company	Name of Policy Holder	Group Number	Member ID	Relationship to Policy Holder

DOB of Policy Holder	SSN of Policy Holder	Emergency Contact	Telephone	Relationship

I understand that I (or guardian signed below) have the primary duty to pay my doctor for services even though a portion of the fees may be payable or reimbursable by an insurance company or other third party payer.

I understand that the determination of the dental care to be given to me by my doctor and the fees to compensate for that care are matters between my doctor and myself. These fees are due at the time that services are rendered; any balance due longer than sixty (60) days from the date of service will be assessed at the rate of 1.5% per month as a service charge.

I understand that I am able to request a copy of the office's HIPPA Notice and Privacy Practices at any time. In addition, I realize that I am able to amend my privacy preferences at any time by written request via email to preferences@rosendentalchicago.com or an in-office request.

I hereby authorize Noah H. Rosen, DMD, to release my insurance company or other third party payer or its representative any information including the diagnosis and the records of any treatment or examination rendered to me.

Signature of Patient

Signature of Guardian (if necessary)

PATIENT PREFERENCES

Preferred Name

Credit Card Number | **Expiration Date**

Security Code | **Billing Zip Code**

What made you choose OUR office today?

Appointment Reminder Preference (please circle)

CALL TEXT EMAIL

Billing Preference (please circle one)

Pay at time of service | Email

Credit card on file | Mail

Pay upfront in cash/check and save 5% for services over $500

Any specific concerns we should be aware of?

OFFICE USE: Scanned/Uploaded:

2800 N Sheridan Rd, Suite 204, Chicago, IL 60657
773-248-6140 – office@rosendentalchicago.com
www.RosenDentalChicago.com

ROSEN ✶ DENTAL

MEDICAL HISTORY

How would you describe your general medical health?

Are you currently pregnant? If so, how far along?

Have you ever been hospitalized or had an operation? (please explain)

Please list any birth control, prescription medications, supplements, vitamins, etc. you are currently taking.

Have you been told you snore or diagnosed with sleep apnea? (Yes/No)

Do you use tobacco? If yes, how much?

Are you allergic to the following?

Acrylic
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Latex
Metals
Penicillin
Sulfa Drugs
Tetracycline
Other ____________________

Have you had any of the following?

Abnormal Bleeding/Hemophilia
Allergies
Anemia
Arthritis/Gout
Artificial Joint
Asthma
Cancer/Chemotherapy-Radiation Therapy
Cardiovascular Disease/Stroke/Heart Attack
Colitis
Congenital Heart Defect
Diabetes
Emphysema
Epilepsy
Heart Disease/Pacemaker/Artificial Valve
Hepatitis
High Blood Pressure/Low Blood Pressure
HIV/AIDS
Osteoporosis/Osteopenia
Rheumatic Fever
Sinus Problems
Skin Disorders
Thyroid Problems
Ulcers
Other ______________________________

General Physician

Phone Number

DENTAL HISTORY

What was the approximate date of your last dental visit and what was done?

Do you clinch/grind your teeth? (Yes/No)

How often do you floss?

Please select any of the following that you have a problem with:

Teeth sensitive to hot
Teeth sensitive to cold
Teeth sensitive to sweets
Teeth sensitive to chewing
Receding gums
Sore gums
Frequent cold sores/canker sores
Bleeding gums

How do you rate your smile on a scale of 1-10? (10 = highest)

If you are not satisfied, would you like to discuss options for improvement? (Yes/No)

If looking for some improvement, please select what you would be interested in discussing: Color Shape/Size Chips Spaces Crooked Teeth Other ____________________

Are you interested in discussing solutions for dental anxiety prior to treatment? YES NO

OFFICE USE: Patient Name: ____________________________ **Office Member Reviewed:** ____________________ **Date:** ____________________

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