DR. RABINOWITZ WELCOMES YOU TO OUR OFFICE!

I understand the information on both sides of this form is necessary to provide me with dental care in a safe manner.

PATIENT INFORMATION

LAST ______________________ PREFERRED NAME ______________
FIRST ______________________ MIDDLE ______________
ADDRESS ______________________
CITY ______________ STATE __________ ZIP __________
HOME PHONE (____) ______________ WORK PHONE (____) ______________
EMAIL ______________________ CELL PHONE (____) ______________
SOCIAL SEC.# ______________________ SEX M F MARITAL STATUS S M D W
BIRTH DATE ______________________ EMPLOYED BY ______________
EMPLOYERS ADD ______________________ CITY ______________
FULL TIME STUDENT? Y N IF YES, SCHOOL ______________ CITY ______________
ZIP ______________ REFERRED BY ______________________

DENTAL HISTORY

PREVIOUS DENTIST ______________ ADDRESS ______________ PHONE (____) __________
HOW LONG SINCE YOUR LAST DENTAL VISIT? ______________ WHAT WAS DONE THEN? ______________
HOW LONG SINCE: YOUR TEETH WERE LAST CLEANED? ______________ LAST FULL SET OF X-RAYS? __________
HOW OFTEN DO YOU: HAVE YOUR TEETH CLEANED? ______________ BRUSH YOUR TEETH? __________
HAVE ANY OF THE FOLLOWING CONDITIONS EVER BEEN PERTINENT TO YOUR MEDICAL OR DENTAL HISTORY?

BLEEDING GUMS	Y	N	PAIN OR RINGING IN EARS	Y	N	BURNING TONGUE	Y	N
TENDER OR SWOLLEN GUMS	Y	N	TIRED JAWS	Y	N	SINUS CONDITION	Y	N
LOOSE TEETH	Y	N	DO YOU CLENCH YOUR TEETH	Y	N	HAVE YOU HAD:		
SENSITIVE TEETH	Y	N	COMPLICATED EXTRACTION	Y	N	Orthodontics (braces)	Y	N
MISSING TEETH NOT REPLACED	Y	N	UNUSUAL DENTAL EXPERIENCES	Y	N	Periodontal (gum) Tx	Y	N
PAINFUL OR SORE AREAS	Y	N	THUMB OR FINGER SUCKING	Y	N	Crown (cap) or Bridges	Y	N

CHIEF COMPLAINT ______________________ ROOT CANAL (ENDODONTICS) .... Y N
ARE YOU HAPPY WITH YOUR SMILE? ______________________
CAN YOU CHEW ON BOTH SIDES? ______________________
ARE THERE ANY FOODS YOU CAN'T EAT? ______________________
IF YOU COULD CHANGE ANYTHING ABOUT YOUR DENTAL HEALTH WHAT WOULD IT BE? ______________________
____
REMARKS ______________________
____
____

MEDICAL HISTORY

Have any of the following conditions ever been pertinent to your medical history?

Cancer	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N	Bladder Trouble	Y	N
Radiation Therapy	Y	N	Low Blood Pressure	Y	N	Multiple Sclerosis	Y	N	Epilepsy	Y	N
Heart Trouble	Y	N	Blood Transfusions	Y	N	Thyroid Condition	Y	N	Hepatitis	Y	N
Rheumatic Fever	Y	N	Ulcer	Y	N	Hay Fever	Y	N	HIV	Y	N
Heart Murmur	Y	N	Emphysema	Y	N	Asthma	Y	N	AIDS	Y	N
Artificial Valve	Y	N	Diabetes	Y	N	Kidney Trouble	Y	N	Venereal Disease	Y	N
Artificial Joints	Y	N	Anemia	Y	N	Latex Allergy	Y	N	Fen-Phen	Y	N

ARE YOU PREGNANT? .... Y N
HAVE YOU EVER BEEN TOLD NOT TO TAKE NOVOCAINE? .... Y N
DO YOU HAVE A COLD? .... Y N
ARE YOU PRESENTLY UNDER THE CARE OF A PSYCHIATRIST? .... Y N
ARE YOU PRESENTLY OR HAVE YOU EVER TAKEN STEROIDS? .... Y N
EVER HAD ABNORMAL BLEEDING FROM EXTRACTION OF TEETH OR CUTS? .... Y N
ARE YOU ALLERGIC TO ANY PARTICULAR MEDICINE OR DRUGS? .... Y N
IF SO, WHICH MEDICINES OR DRUGS? ______________________
LIST ALL DRUGS OR MEDICATIONS YOU ARE PRESENTLY TAKING OR HAVE TAKEN IN THE PAST 12 MONTHS.
____

IN CASE OF EMERGENCY NOTIFY ______________ PHONE (____) __________ RELATION __________
PHYSICIAN ______________ PHONE (____) __________ LAST EXAM ______________

RESPONSIBLE PARTY

LAST ______________________________ TITLE ______________

FIRST ______________________________ MIDDLE ______________

ADDRESS ____

CITY ____________________ STATE ____________ ZIP ____________

HOME PHONE (_____) ____________________ BIRTH DATE ______________

WORK PHONE (_____) ______________ SEX M F SOCIAL SEC. # ______________

NUMBER OF CHILDREN ________ DRIVERS LICENSE # ____________ STATE ______

Preferred method of payment CASH CHECK CREDIT CARD

Nearest friend or relative NOT living in same household:

Name ______________________________ Phone (_____) ______________

INSURANCE

PRIMARY DENTAL INSURANCE:

EMPLOYER'S NAME ______________________________ PHONE (_____) ______________

ADDRESS ____________________ CITY ____________ St. ______ ZIP ____________

EMPLOYEE'S NAME ______________________________ RELATION TO PATIENT ______________

GROUP # ____________ EMPLOYEE # ____________ SOCIAL SECURITY # ____________ DOB ____________

INSURANCE COMPANY NAME ______________________________________

ADDRESS ____________________ CITY ____________ St. ______ ZIP ____________

PHONE # (_____) ______________

CONSENT

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication. I authorize the doctor or his staff to take any necessary x-rays, models, photos, and other diagnostic aids needed to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and staff to perform and administer treatment, medication, and therapy that may be indicated.

AGREEMENT TO PAY

Payment for dental services provided in this office for myself and my dependents are due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a billing charge may be added to my account. If an account must be turned over to a collection agency the fee charged by that agency will be added to my account.

Signature ____ Date ______________

(Patient or Parent / Guardian if Minor)