



**Fred M. Rabinowitz DDS, PA**  
Family & Cosmetic Dentistry

To return the new patient form to us via secure HIPAA compliant e-mail:

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4. Click on compose email.
5. Type in our address [fred@rabinowitzdds.com](mailto:fred@rabinowitzdds.com) . Then attach your saved new patient form (image of a paper clip)
6. Your form will be sent to us securely via HIPAA compliant email.

To return the form to us via NON-SECURE e-mail or Fax :

1. Download and fill out the new patient form
2. Save it to your computer
3. E-mail it to [fred@rabinowitzdds.com](mailto:fred@rabinowitzdds.com) or FAX it to 972-867-5900



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**CALL US AT:  
(972) 867-5989**

**Patient Information**

LAST \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_  
 FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 CELL PHONE ( \_\_\_\_\_ ) \_\_\_\_\_ EMAIL \_\_\_\_\_  
 SEX M F MARITAL STATUS S M D W  
 BIRTH DATE \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_  
 COMPANY ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
 FULL TIME STUDENT? IF YES, SCHOOL \_\_\_\_\_  
 CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 DRIVER'S LIC. \_\_\_\_\_ SOCIAL SECURITY NO. - -  
 HOW DID YOU HEAR ABOUT US?  
 HAVE YOU SEEN US ON: FACEBOOK GOOGLE+ NEXT DOOR APP YELP HEALTH GRADES

Dental History 

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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	BURING TONGUE	Y	N
TENDER OR SWOLLEN GUMS	Y	N	TIRED JAWS	Y	N	SINUS CONDITION	Y	N

LOOSE TEETH	Y	N	DO YOU CLINCH 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
						Crown (cap) or Bridges	Y	N
PAINFUL OR SORE AREAS	Y	N	THUMB OR FINGER SUCKING	Y	N	Root Canal (Endodontics)	Y	N
CHIEF COMPLAINT								

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

REMARK

**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

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 NAME

TITLE

FIRST NAME

MIDDLE

ADDRESS

CITY

STATE

ZIP

HOME PHONE (            )

WORK PHONE (            )

BIRTH DATE

SEX

M

F

NUMBER OF CHILDREN

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

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 aides needed to make a thorough diagnosis of the patients 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.

*Please type your name below, indicating the above information is correct. Typing your name indicates your approval and acts as a signature.*

Signature

Date