Fred M. Rabinowitz DDS, PA
Family & Cosmetic Dentistry

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

1. Download and fill out the new patient form
2. Save it to your computer
3. Go to www.enlocked.com and open a FREE account.(You will not receive any junk mail or solicitations and your e-mail address will not be given out)
4. Click on compose email.
5. Type in our address 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 or FAX it to 972-867-5900

Fred M. Rabinowitz DDS, PA
Family & Cosmetic Dentistry

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

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

IF YES, LIST THE MEDICINE OR DRUGS YOU ARE ALLERGIC TO:

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 heatlh 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 _____