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Creating Generations of Smiles

Adult History Form for the Office of Marvin Rosenberg D.D.S.

Today's date:_____

General Information

Patient name:_____ Age:_____ Date of Birth:_____

Sex: ☐ Male ☐ Female Social Security #:_____

Address:_____ Cell ( )_____

_____ Tel.( )_____
City State Zip

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer: _____ How long there? _____

Employer's Address: _____Work Tel.( )_____

Where and when are the best times to reach you? _____

Whom may we Thank for referring you?_____

Names of other family members seen by us?_____

Family Dentist:_____ Last Visit Date:_____

Family Physician: _____ Last Visit Date: _____

What are your concerns about your teeth? _____

_____

Medical History:

Have you had or do you have any of the following?

Y N Anemia
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defects
Y N Diabetes / Tuberculosis
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy/Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Your current general health is: ☐ Good ☐ Fair ☐ Poor

Y N Are you currently under the care of a physician? If yes, reason

_____

Y N Are you currently taking any medication? If yes, describe

_____

Y N Are you allergic to any medications? (E.g.: aspirin, penicillin, etc.) If yes,

_____

Y N Have you ever had any general anesthesia? When?

_____

For Women:

Y N Are you taking birth control pills?

Y N Are you pregnant? Week # _____

Y N Are you nursing?

Dental History:

Y N Have you ever had or a serious/ difficult problem associated with past dental work?

Y N Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ)?

Y N Do you clench / grind your teeth?

Y N Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Y N Do your jaw muscles ever feel tired? If yes, when _____

Y N Does it hurt to chew? If yes, when _____

Y N Do you hear clicking (popping) or grating sounds in your jaw joints?

Y N Have your jaws ever "locked" on you?

Y N Do you like your smile?

Y N Do your gums ever bleed? If yes, how often _____

Y N Have you ever had treatment for periodontal disease (gum disease)?

Y N Do you have any missing or extra permanent teeth?

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is **my** responsibility to inform this office of any changes in my medical status. *I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

_____

Signature Date

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature Date

Thank you for filling out this form completely.

INSURANCE INFORMATION

Primary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Secondary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____