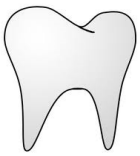
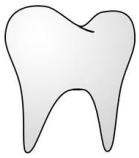


Comprehensive Family Dentistry

Dr. Graham Rose & Dr. Martine Rose



Patient Information

DATE_____NAME_____
Last First Middle Initial Preferred Name

ADDRESS_____
Street Apt# City State Zip

HOME PHONE_____WORK PHONE_____CELL PHONE_____

DATE OF BIRTH_____ SSN#_____SEX ☐MALE ☐FEMALE

MARITAL STATUS_____ EMAIL_____

EMPLOYER_____OCCUPATION_____

EMPLOYER'S ADDRESS_____
Street City State Zip

SPOUSE'S NAME_____SPOUSE'S BIRTHDATE_____

SPOUSE'S WORK NUMBER_____SPOUSE'S CELL NUMBER_____

SPOUSE'S EMPLOYER_____SPOUSE'S SSN#_____

PATIENT'S EMERGENCY CONTACT_____

PHONE NUMBER(S) _____RELATIONSHIP TO PATIENT_____

.....

Insurance Information

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

SUBSCRIBER'S NAME_____RELATIONSHIP TO PATIENT_____

INSURANCE CARRIER_____GROUP#_____

SSN OR ID# OF SUBSCRIBER_____SUBSCRIBER'S DATE OF BIRTH_____

.....

ASSIGNMENT AND RELEASE

I CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE. I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION TO ANY INSURANCE COMPANY THAT IS NECESSARY TO PROCESS THE CLAIM. I REQUEST PAYMENT OF BENEFITS BE MADE TO COMPREHENSIVE FAMILY DENTISTRY (also known as ROSE & ROSE DDS, PC). I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE OF PATIENT OR GUARDIAN_____

DATE_____RELATIONSHIP TO PATIENT_____

Dental History

REASON FOR TODAY'S VISIT_____

FORMER DENTIST_____FORMER DENTIST PHONE NUMBER_____

DATE OF LAST VISIT_____DATE OF LAST XRAYS_____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

PLEASE CIRCLE BELOW TO INDICATE IF YOU DO, DID, OR HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH
BLEEDING GUMS
BLISTERS ON LIPS OR MOUTH
BURNING SENSATION ON TONGUE
CHEW ON ONE SIDE OF MOUTH
CIGARETTE, PIPE OR CIGAR SMOKING
CLICKING OR POPPING JAW
DRY MOUTH
FOOD COLLECTION BETWEEN TEETH
GRINDING TEETH
GUMS SWOLLEN OR TENDER
JAW PAIN AND TIREDNESS
LOOSE TEETH OR BROKEN FILLINGS
MOUTH BREATHING
MOUTH PAIN WHEN BRUSHING
ORTHODONTIC TREATMENT
PAIN AROUND EAR
PERIODONTAL TREATMENT
SORES OR GROWTHS IN YOUR MOUTH

.....

Medical History

PHYSCIAN'S NAME_____DATE OF LAST VISIT_____

LIST **MEDICATIONS** BELOW:

_____
_____
_____
_____
_____
_____
_____
_____

LIST ALL **ALLERGIES** BELOW:

_____
_____
_____
_____
_____

ARE YOU PREGNANT? IF SO, PROVIDE DUE DATE.

_____

PLEASE CIRCLE BELOW TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV
ANEMIA
ANXIETY
ARTHRITIS
ARTIFICIAL HEART VALVES
ARTIFICIAL JOINTS
ASTHMA
BLEEDING ABNORMALLY
BLOOD DISEASE
CANCER
CHEMICAL DEPENDENCY
CHEMOTHERAPY
CIRCULATORY PROBLEMS
CONGENITAL HEART LESIONS
CORTISONE TREATMENTS
COUGH, PERSISTENT
DIABETES / INSULIN PUMP
EMPHYSEMA
EPILEPSY
FAINTING OR DIZZINESS
GLAUCOMA
HEADACHES
HEART MURMUR
HEART PROBLEMS
HEPATITIS TYPE_____
HERPES
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
JAUNDICE
KIDNEY DISEASE
LIVER DISEASE
LOW BLOOD PRESSURE
MITRAL VALVE PROLAPSE
NURSING/BREAST FEEDING
PACEMAKER /DEFIBRILLATOR
PSYCHIATRIC CARE
RADIATION TREATMENT
RESPIRATORY DISEASE
RHEUMATIC FEVER
SCARLET FEVER
SHORTNESS OF BREATH
SINUS TROUBLE
SKIN RASH
STROKE
SWOLLEN FEET OR ANKLES
THYROID PROBLEMS
TONSILLITIS
TUMORS (HEAD OR NECK)
ULCER

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? IF SO, PLEASE EXPLAIN: _____

_____

OTHER CONDITIONS NOT LISTED ABOVE THAT YOU FEEL WE SHOULD KNOW ABOUT: _____

_____

PHARMACY NAME_____PHARMACY NUMBER_____

DENTIST'S SIGNATURE_____