

ADULT A B C

Thomas Rosenbarger D.D.S. P.C.

Today's date: _____

Patient's Name: _____ Age: _____ Birthdate: _____
 Name you like to be called: _____ Who may we thank for referring you to our office? _____
 Hm Phone: _____ Work: _____ Cell: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Do you play a musical instrument? Yes No
 Employer: _____ No. of years employed: _____
 Occupation: _____ Social Security #: _____

RESPONSIBLE PARTY

Same as above

Name: _____ Marital Status: _____
 Address: _____ State: _____ Zip: _____
 Mailing Address (if different from above): _____ State: _____ Zip: _____
 How long at this address? _____
 Previous Address (if less than 3yrs): _____ State: _____ Zip: _____
 Spouse's Name: _____
 Employer: _____ Occupation: _____ No. of years employed: _____
 Social Security #: _____ Birthdate: _____ Work: _____

INSURANCE INFORMATION

Insured Name: _____ Insured's S.S. # _____ Insurance Co.: _____
 Insurance Co. Address: _____ Group #: _____
 Phone: _____ Insured's Employer: _____
 Do you have dual coverage? Yes No If yes: _____
 Insured's Name: _____ Insured's S.S.#: _____ Insured's Employer: _____
 Ins. Co.: _____ Group #: _____ Phone: _____
 Insurance Co. Address: _____

MEDICAL / DENTAL HISTORY

Physician Name: _____ Phone: _____
 Dentist Name: _____ Phone: _____
 Yes No Are you currently under any medical treatment? _____
 Yes No Do you have pain, clicking, and/or popping noises in the jaw? _____
 Yes No Are you aware of either clenching or grinding of teeth? _____
 Yes No Do you have frequent headaches? How often? _____
 Yes No Do you have ear problems? (Aches, ringing, dizziness, fullness) _____
 Yes No Do you have difficulty breathing through the nose? _____
 Yes No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting? _____
 Yes No Do you have speech problems, or are you in speech therapy? _____
 Yes No Have you had your tonsils and / or adenoids removed? _____
 Yes No Has there been any history of: Joint swelling Asthma TB Aids Kidney Liver Condition Epilepsy
 Rheumatic fever Other major illness? _____
 Yes No Do you bleed easily? _____
 Yes No Is there a tendency to faint or become dizzy? _____
 Yes No Do you have allergies? (Sulphur, penicillin, novocaine, etc.) _____
 Yes No Are you currently taking any medication? List: _____
 Yes No Do you have a heart murmur? Do you pre-medicate? Yes No Cardiologist _____
 Yes No Do you have sleep apnea? _____
 Yes No Do you smoke or chew tobacco? _____
 Yes No Have there been any injuries to the teeth? _____
 Yes No Were any teeth removed by extractions? _____
 Yes No Have we treated any family members? Who: _____
 How did you hear from us? Patient Referral Staff Referral Dental Referral Other _____

I understand where appropriate a credit report may be obtained

Signature _____ Date _____