

# Thomas G. Rosenbarger D.D.S. P.C.

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Name you like to be called: \_\_\_\_\_ Hm Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Do you play a musical instrument?  Yes  No  
Who may we thank for referring you to our office? \_\_\_\_\_

## RESPONSIBLE PARTY

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: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
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 condition?  Yes  No 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 Have you had any permanent teeth extracted? \_\_\_\_\_  
 Yes  No Have we treated any other family members?  Yes  No Who: \_\_\_\_\_

*I understand where appropriate a credit report may be obtained*

Signature \_\_\_\_\_ Date \_\_\_\_\_

