STEPHEN B. ROSENBERG
appearance related & general dentistry

Dr. Stephen Rosenberg
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NEW PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL.)

Patient's Name:_____
Last First Initial

Address:_____ Age:_____Birthday:_____ ☐ Male ☐ Female
Street City Zip

Patient: ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Separated ☐ Widowed E-mail:_____

Minor Patients, Name of Parent or Legal Guardian:_____Relationship:_____

Please provide the following:

Social Security No.:_____Res. Phone: (____)_____

Employed by:_____How long:_____ Occupation:_____

Employer's Address:_____Bus. Phone: (____)_____
Street City Zip

Spouse's Name:_____ Social Security No.:_____

Name of emergency contact:_____ Relationship:_____

Address:_____ Day Phone: (____)_____
Street City Zip

Personal Physician:_____(____)_____ ☐ I have no physician
Address Phone

If you were referred to our office, we would like to thank them. Please give us their name: _____

FINANCIAL INFORMATION

Person responsible for this account: _____ Relationship: _____(___)_____
Phone

Address: _____ Cell Phone No.:(___) _____
Street City Zip

Name of Primary Dental Insurance Company: _____

Insured Person's Name: _____ Relationship: _____ Date of Birth: _____ SS No.: _____

Employer: _____Group No.: _____

Name of Secondary Dental Insurance Company:_____

Insured Person's Name: _____ Relationship: _____ Date of Birth: _____ SS No.: _____

Employer: _____Group No.: _____

NOTICE OF PRIVACY PRACTICES

☐ I hereby acknowledge, I have received a copy of Dr. Stephen Rosenberg's "Notice of Privacy Practices." I further understand that Dr. Stephen Rosenberg's business office will offer me updates to "Notice of Privacy Practices" should it be amended, modified, or changed in any way.

Signed: _____Print Name:_____Date:_____

TERMS AND CONDITIONS

As a condition of treatment by the office of Dr. Stephen Rosenberg, I understand financial arrangements must be made in advance. This practice depends upon reimbursement from the patient for the costs incurrred in their care. Financial responsibility on the part of the patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangementss, must be paid for in cash at the time service is performed.

I understand that dental services provided to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such credits to my account. However, this dental office cannot render service on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to the office of Dr. Stephen Rosenberg benefits accruing to me under my policy.

A service charge of 1-1/2% per month (18% per annum) (but in no event more than the maximum rate permitted under Florida state law) will be charged on the unpaid principal balance. On all accounts not paid within 60 days of service provided.

I understand that the fee estimate provided for this dental procedure can only be extended for a period of six (6) months from patient's examiniation.

In consideration of professional services rendered to me, or at my request, by Dr. Stephen Rosenberg and/or his staff, I agree to pay Dr. Stephen Rosenberg or his assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any terms or conditions here under shall not consittue a waiver of any further terms or conditions. I further agree that in the event that either this office or I institute anny legal proceedings with respect to amounds owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attourneys and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed: _____Print Name:_____Date:_____

MEDICAL HISTORY

Please answer each question. Your medical history is very important in planning your dental treatment.

1. Are you in good medical health? ☐ Yes ☐ No
2. Date of your last physical examination. _____
3. Are you presently under care of a physician? ☐ Yes ☐ No
   If you are, what are you being treated for ? _____
4. Have you ever been treated for a serious illness or operation? ☐ Yes ☐ No
   If you have, what illness or operation. _____
5. Have you ever been hospitalized ? ☐ Yes ☐ No
   If you have, what was the problem? _____
6. Are you taking any: ☐ medications, ☐ drugs, ☐ herbs? ☐ Yes ☐ No
   If you are, what? _____ Dosage: _____
   _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? ☐ Yes ☐ No
8. Are you sensitive or allergic to any drugs or materials? ☐ Yes ☐ No
   ☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ SulfaDrugs ☐ Tetracycline ☐ Other _____
9. Do you have or have you had any of the following: (Circle "Y" for YES and "N" for NO)

Y N Acquired Immune Deficiency Syndrome (AIDS) (HIV)	Y N Chemotherapy	Y N Heart Murmur	Y N Rheumatic Fever
Y N Allergies or Hives	Y N Congenital Heart Lesions	Y N Hemophilia	Y N Rheumatism
Y N Allergies to Metals	Y N Cortisone Medicine	Y N Hepatitis or Jaundice	Y N Scarlet Fever
Y N Anemia	Y N Diabetes	Y N Herpes	Y N Sickle Cell Disease
Y N Angina Pectoris	Y N Difficulty Swallowing	Y N High Blood Pressure	Y N Sinus Trouble
Y N Arthritis	Y N Drug Addiction	Y N Implants	Y N Stroke
Y N Artificial Joints	Y N Emphysema	Y N Kidney Disease	Y N TMJ (Temporomandibular Joint) Disorder
Y N Asthma	Y N Epilepsy or Seizures	Y N Liver Disease	Y N Thyroid Disease
Y N Blood Disease	Y N Fainting Spells	Y N Mitral Valve Prolapse	Y N Tonsillitis
Y N Blood Transfusion	Y N Glaucoma	Y N Osteoporosis	Y N Tuberculosis (TB)
Y N Bruise Easily	Y N Headaches	Y N Pain in Jaw Joints	Y N Tumors or Growths
Y N Cancer	Y N Head Injuries	Y N Psychiatric Treatment	Y N Ulcers
Y N Cerebral Palsy	Y N Heart Attack	Y N Radiation Treatment of any kind	Y N Venereal Disease (Syphilis, Gonorrhea)
	Y N Heart Failure	Y N Respiratory Disease	

10. Do you have any condition or disease not listed above? ☐ Yes ☐ No
    If so, what? _____
11. Do you wear a Cardiac Pacemaker, or have you had heart surgery? ☐ Yes ☐ No
12. Do you smoke? If you do, how much? ☐ Cigarettes Packs per day _____ ☐ Cigars ☐ Pipe ☐ Yes ☐ No
13. (Women) Do you take any birth control medication or hormones? ☐ Yes ☐ No
14. (Women) Are you Pregnant? If so how many months? ☐ Yes ☐ No

DENTAL HISTORY

1. Any concerns, problems or pain with your teeth at this time? ☐ Yes ☐ No
   Please explain: _____
2. How long since your last dental treatment? ☐ Yes ☐ No
3. Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No _____ Age Wisdom teeth extracted? ☐ Yes ☐ No
4. Have you had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No
   If you have please explain? _____

CONSENT FOR TREATMENT

I herby grant authority to Dr. Stephen Rosenberg and associate dentist(s) in charge of the care of the patient whose name appears on this Patient Information and Health History form, to administer such anesthetics, analgesics, sediatives, nitros oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I will be informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions on the reverse side of this form.

Authorization must be signed by the patient, legal guardian in the case of a minor or a patient that is physically or mentally incompetent.

Signed: _____ Print Name: _____ Date: _____

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