Chart #:

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (**Home**):_____(**Work**):_____Ext:

(**Cell**) _____

Email:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Date of Last Dental Visit: _____ Reason for this visit: _____

Health Information

Please inform us of any medications that you are currently taking: _____
Do you premedicate [] YES [] NO, if Yes Why? _____
What medications do you take to premedicate? _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment only? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:** _____
Signature of «FName» «MI» «LName», parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Patient, friend ☐ Patient, relative ☐ Other_____
Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell) _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.

The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patients insurance forms or assist in collection from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot and does not render services on the assumption that our charges will be paid by an insurance company. The insurance benefits are assigned to treating doctors unless otherwise arranged.

I understand that the fee estimate and predeterminations submitted on your behalf for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to _____, by **Drs. Rosen & Deutch**, I agree to pay therefore the reasonable value of said services to **Drs. Rosen & Deutch**, at the time said 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Payment Arrangement

In an effort to provide you with a flexible payment arrangement;
we have expanded our payment policy.

If you do not have insurance or to clear your balance after insurance payment have been made, we now offer the followed payment options:

___ **Payment in full** – includes cash, personal checks or money orders.

__ **Payment by credit card** – automatic monthly billing to your credit card.
For your convenience we accept Visa, MasterCard, American Express and Discover credit cards.

Please make your choice which can be changed at anytime.
Sign below and return to the front desk prior to treatment.

X _____ Date: _____
Signature

A broken appointment is a loss to everyone. Please be advised that there will be an automatic charge for missed, canceled **or** rescheduled appointments without **24 – hours** notice.
Please sign to acknowledge that you are aware of our office policy.
Many thanks in advance.

X _____ Date: _____
Signature

Dental Sleep Questionaire

Obstructive Sleep Apnea (OSA)

OSA is a serious illness that has been linked to hypertension, diabetes, erectile dysfunction, heart failure, arrhythmias, heart attack, stroke, gastric-esophageal reflux disease (GERD), nocturia, and early death!

Please answer the following questions to help us identify who is at risk for OSA and to better treat you.

Name:_____ Date:_____

1. Do you *snore* loudly or have been told that you snore? YES:_____ NO:____
2. Do you ever awaken with a sensation of gasping or choking? YES:_____ NO:____
3. Has anyone ever noticed that you stop breathing during your sleep? YES:_____ NO:____
4. Do you often wake up with dry mouth? YES:_____ NO:____
5. Do you find your sleep to be non-refreshing? YES:_____ NO:____
6. Do you often feel tired, fatigued, or sleepy during daytime? YES:_____ NO:____
7. Do you ever fall asleep or nod off in situations where you did not intend to? YES:_____ NO:____
8. Do you have (or are being treated for) high blood pressure and/or diabetes? YES:_____ NO:____
9. Any other concerns regarding sleep/snoring or possible apnea please write here: