Resnick & Rosenfeld DDS
CARING CONTEMPORARY & COSMETIC DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Social Security #: _____ Birth Date: _____

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

E-Mail _____ Fax: _____ Best Time To Call _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency contact information _____

Health Information

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

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

☐ AIDS or HIV Positive
☐ Allergies _____
_____
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Cold Sores/Fever Blisters
☐ Contact Lenses
☐ Cortisone Medication
☐ Diabetes
☐ Diet (Restricted)

☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice

☐ Kidney Disease
☐ Latex Sensitivity
☐ Liver Disease
☐ Neurological Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date: _____
☐ Psychological Disorders
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis

☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

☐ Other Allergic Adverse Reactions to Medication or Substances _____
_____
_____

☐ Are you taking any other medications?
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ 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 patient, parent or guardian

Referral Information

How did you hear about our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Who may we thank for referring you to our practice? _____

Spouse or 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: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

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

Patient's 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

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and employ such assistance as required to provide proper care.

I agree to the use of anesthetics, analgesics, and other medication as necessary. I fully understand that using such agents embodies certain risks. I understand that I can ask for and receive a complete recital of any possible complications.
I agree to be responsible for payment of the reasonable value of all services rendered to me. I understand that payment is due at the time services are rendered unless previous written financial arrangements are made. I agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within five days of the service. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. 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.

If I have dental insurance, I have read and understand the office policy statement entitled "About Financial Arrangements and Dental Insurance"._____ (Initials please)

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

Dental Information

Are you pleased with the appearance of your teeth?_____

Is there anything about your smile that you do not like?_____

Would you like whiter teeth?_____

Do you think your teeth are straight enough?_____

Do you have any missing teeth?_____

Are any of your teeth chipped or broken?_____

When you chew, does your bite feel comfortable?_____

Are you aware of any clenching or grinding of your teeth?_____

Does your jaw ever lock in the open or closed position?_____

Do you have frequent headaches?_____

Do your gums ever bleed?_____

If yes to the above question, is it spontaneous, or on brushing or flossing?_____

Do you sense a bad taste or odor in your mouth?_____

Do you use any fresh breath products? (either professional of over the counter)_____

Have you ever been told you had gum disease?_____

Have you ever had a sample of bacteria taken from between your tooth and gum and had it examined under a microscope?_____

Do you have any prior dental treatment that you are unhappy with?_____

Do you smoke?_____ If so, how much?_____

Have you ever had complications from either oral or any other type of surgery?_____

Is there anything else you would like us to know?_____

Esthetic Evaluation

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment to answer the following questions. Please circle your answer.

If you are completely satisfied with the appearance of your teeth and smile there is no need to fill out this form.

Name: _____Date:_____

1. Do you dislike the color of your teeth? No
2. Do you have spaces between your teeth that bother you? No
3. Do you have chips or uneven edges on your teeth? No
4. Do you feel that your teeth are too long or too short? No
5. Do you have dark fillings that show when you smile? No
6. Do your gums show too much when you smile? No
7. Are your teeth too crowded or crooked? No
8. Do you have crowns or dental work that you consider ugly? No
9. Are you self – conscious about your teeth or smile? No
10. Has anyone (friend, family member, etc.) ever suggested that you do something about your teeth or smile? No
11. Do you avoid smiling when you have your picture taken? No
12. Would you like to improve your existing smile? No
13. Do you wish you had a “new smile”? No

What concerns do you have regarding dental treatment to improve your smile?

☐ Fear of treatment. ☐ Time of treatment. ☐ Financial concerns

☐ Distance to the office. ☐ Not understanding treatment. ☐ Embarrassment

Thanks!

Submit