Nancy R. Rosenthal, DDS
1250 Greenwood Ave, Suite 10 | Jenkintown, PA 19046 | 215-887-4004

PATIENT INFORMATION

Date*:* _____

Patient Name: _____ Birth Date: _____ Gender:_____

Preferred Phone: _____ Other Phone:_____

Work Phone: _____ Email:_____

Address: _____
Street

_____
City State Zip Code

Social Security #*:* _____

Occupation: _____ Employer:_____

Do you like the appearance of your teeth and smile? ❒ Yes ❒ No

What would you like to change most in the appearance of your teeth? _____

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

HEALTH INFORMATION

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

Please answer Yes or No to the following:

Allergies

Y	N	
❒	❒	Penicillin
❒	❒	Codeine
❒	❒	Aspirin
❒	❒	Sulfa
❒	❒	Local Anesthetics
❒	❒	Any Metals_____
❒	❒	Other (list below)

Medical History

Y	N	
❒	❒	Anemia
❒	❒	Arthritis
❒	❒	Artificial Joints
❒	❒	Asthma or Lung Disease
❒	❒	Bleeding Disorders

Medical History, continued

Y	N	
❒	❒	Cancer
❒	❒	Diabetes
❒	❒	Dizziness
❒	❒	Epilepsy
❒	❒	Fainting
❒	❒	Glaucoma
❒	❒	Gout
❒	❒	Heart Disease
❒	❒	Heart Murmur
❒	❒	Hepatitis
❒	❒	High Blood Pressure
❒	❒	HIV or AIDS
❒	❒	HPV
❒	❒	Kidney Disease
❒	❒	Liver Disease

Medical History, continued

Y	N	
❒	❒	Low Blood Pressure
❒	❒	Mental Disorders
❒	❒	Nervous Disorders
❒	❒	Pacemaker
❒	❒	Radiation Treatment
❒	❒	Respiratory Problems
❒	❒	Rheumatic Fever
❒	❒	Rheumatism
❒	❒	Sinus Problems
❒	❒	Stomach Problems
❒	❒	Stroke
❒	❒	Substance Abuse
❒	❒	Tuberculosis
❒	❒	Tumors
❒	❒	Ulcers
❒	❒	Venereal Disease

Other allergies or medical conditions not mentioned above: _____

_____

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HEALTH INFORMATION, continued

Medications you are taking: _____

_____

Have you ever been advised to Pre-Medicate for dental procedures? ❒ Yes ❒ No

Have you had a recent Oral Cancer Screening? ❒ Yes ❒ No

Have you ever had any complications following dental treatment? ❒ Yes ❒ No

If yes, please explain: _____

Family Doctor _____ Phone # _____

FINANCIAL INFORMATION

Dental Insurance? ❒Yes ❒No

Insurance Company:_____

Is this a DMO, HMO, DHMO or Savings Program? ____

Insured's Name_____ DOB _____

Group Name & Number: _____

Insured's Social Security Number _____

Patient's Relationship to Insured ❒Self ❒Spouse ❒Child ❒Other _____

Is Patient a Full Time Student? ❒Yes ❒No If so, where? _____

Secondary Insurance? ❒Yes ❒No

Insurance Company _____

Insured's Name_____ DOB _____

Group Name & Number: _____

Insured's Social Security # (if different from above) _____

Patient's Relationship to Insured ❒Self ❒Spouse ❒Child ❒Other _____

PATIENT SIGNATURE

By signing this form I attest that I have answered all of the Patient, Financial and Medical questions on this form to the best of my knowledge. I understand that I am financially responsible for charges not covered by insurance. Should costs be incurred for collections, I understand that I will be responsible for the cost of collections including attorney's fees and interest. I further understand that I may be charged for missed appointments unless at least 24 hours notice is given.

_____ _____

Signature of Patient (or parent, if patient is a child) Date