Rosemont Dental Center

Patient Information

Name: _____ Date of Birth: _____

Address:_____

Email: _____ Phone: (H):_____ (C):_____

Emergency Contact: _____ Relation: _____ #:_____

Were you referred to our office? If yes, who referred you? _____

Primary Insurance Information

Name of the insured: _____ Relation: _____

Social Security #:_____ Date of Birth: _____

Address (if different than above): _____

Employer: _____ Phone #: _____

Insurance Company: _____ Member ID#: _____

Group #: _____ Providers Phone #: _____

Insurance Claims Address: _____

Secondary Insurance Information

Name of the insured: _____ Relation: _____

Social Security #:_____ Date of Birth: _____

Address (if different than above): _____

Employer: _____ Phone #: _____

Insurance Company: _____ Member ID#: _____

Group #: _____ Providers Phone #: _____

Insurance Claims Address: _____

Authorization and Release

To the best of my knowledge the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever has a change in health. I certify that I, and/or my dependent(s), have insurance coverage, as listed above, and assign directly to **Dr. Askari** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____

Signature Date Relation to Patient

Print Name:_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Rosemont Dental Center

Dental History

Reason for today's visit: _____ Date of last dental care: _____

Former Dentist: _____ Phone#: _____

How often do you floss? _____ How often do you brush? _____

Please circle if you have had problems with any of the following:

Bad breath	Grinding teeth	Clicking popping jaw	Sores or growths	Bleeding gums
Loose/broken teeth	Food collection between the teeth	Periodontal treatment	Sensitivity to: hot / cold / sweets / when biting	

Medical History

Physician Name: _____ Phone: _____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen?” These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes / No

Have you had any serious illnesses or operations? Yes / No

If yes, describe: _____

Have you ever had a blood transfusion? Yes / No If yes, aprx. date(s): _____

(Women) Are you pregnant?: Yes / No Nursing?: Yes / No Taking birth control pills? Yes / No

Circle if you have had any of the following:

Anemia	Arthritis, Rheumatism	Artificial Heart Valves	Artificial Joints, Pins, etc
Asthma	Back Problems	Bleeding Abnormally	Blood Disease
Cancer	Chemical Dependency	Circulatory Problems	Congenital Heart Lesions
Cough, Persistent	Cortisone Treatments	Cough up Blood	Diabetes
Epilepsy	Fainting	Glaucoma	Headaches
Heart Murmur	Heart Problems	Hemophilia	Hepatitis -- A / B / C
HIV/AIDS	High Blood Pressure	Hernia Repair	Jaw Pain
Kidney Disease	Liver Disease	Mitral Valve Prolapse	Pacemaker
Radiation Treatment	Respiratory Disease	Rheumatic Fever	Scarlet Fever
Skin Rash	Shortness of Breath	Stroke	Swelling of feet/ankles
Thyroid Problems	Tobacco Habit	Tonsillitis	Ulcer Venereal Disease

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