



**ROSE DENTAL GROUP**

**PATIENT INFORMATION**

Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_

Hm. Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Sex (Circle) M or F Drivers Lic. # \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Marital Status (Circle) Single or Married

**POLICY HOLDER INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_

Hm. Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Sex (Circle) M or F Drivers Lic. # \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

**Person to contact outside of immediate family in case of emergency**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Alternative # \_\_\_\_\_

**REFERRAL SOURCE**

Family Member \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Sign \_\_\_\_\_ Mail \_\_\_\_\_ Website \_\_\_\_\_ Other \_\_\_\_\_

Thank you for choosing us. All information you give us is strictly confidential and will not be released to anyone without written consent.

Signature (Patient, Parent, or Guardian)

Date



**ROSE DENTAL GROUP**

**PATIENT HEALTH and DENTAL INFORMATION (Page 1)**

**MEDICAL HISTORY**

Do you have any of the following:

- |                          |                          |                         |                          |                          |  |                          |                          |   |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |                         | <b>Yes</b>               | <b>No</b>                |  | <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Fainting tendency  | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory problems<br>(Asthma, emphysema, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                  | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis               | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems (Heart<br>Murmur, Valvular Defect,<br>or Replacement) | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Valve        | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (infectious)   | <input type="checkbox"/> | <input type="checkbox"/> | Stroke  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion       | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B (serum)  | <input type="checkbox"/> | <input type="checkbox"/> | Tested positive for AIDS/HIV                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory problems    | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice   | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD                    | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement  | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                | <input type="checkbox"/> | <input type="checkbox"/> | Malignancies   | <input type="checkbox"/> | <input type="checkbox"/> | Unfavorable reaction to<br>dental anesthetic      |
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnosis of ARC/HIV    | <input type="checkbox"/> | <input type="checkbox"/> | Nursing mother currently?  | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant currently?  |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive bleeding      | <input type="checkbox"/> | <input type="checkbox"/> | Due Date _____   |                          |                          |   |

Other \_\_\_\_\_

Do you have a condition that requires antibiotic premedication before dental appointments (Y or N)?

Do you use any tobacco products? (Y or N) If YES, what type? \_\_\_\_\_

Are you allergic to any medications? (Y or N) If YES, please list \_\_\_\_\_

Are there any other medical conditions of which we should be made aware? \_\_\_\_\_

Physician's Name & Phone # \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Preferred Pharmacy & Phone # \_\_\_\_\_

Are you presently under the care of a physician? (Y or N) If YES, for what? \_\_\_\_\_

Have you ever been hospitalized? (Y or N) If YES, for what? \_\_\_\_\_

Are you currently taking any medication? (Y or N) If YES, please list \_\_\_\_\_

**DENTAL HISTORY**

Are you currently experiencing a toothache or any other pain in your head or neck? If yes, please describe: \_\_\_\_\_

Date of your last dental treatment or cleaning? \_\_\_\_\_ Date of last dental X-Rays \_\_\_\_\_ What type? \_\_\_\_\_

Do you have a history of:

- |                          |                          |                |                          |                          |                           |                          |                          |                          |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|
| <b>Yes</b>               | <b>No</b>                |                | <b>Yes</b>               | <b>No</b>                |                           | <b>Yes</b>               | <b>No</b>                |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Gum Disease    | <input type="checkbox"/> | <input type="checkbox"/> | Halitosis (Bad Breath)    | <input type="checkbox"/> | <input type="checkbox"/> | Grinding Teeth (BRUXISM) |
| <input type="checkbox"/> | <input type="checkbox"/> | Abscesses      | <input type="checkbox"/> | <input type="checkbox"/> | Teeth Sensitivities       | <input type="checkbox"/> | <input type="checkbox"/> | Clicking or Popping TMJ  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores (Ulcers) | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores/Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joint        |

Are there any other dental conditions or experiences of which we should be made aware? \_\_\_\_\_

**PATIENT HEALTH and DENTAL INFORMATION (Page 2)**

**SMILE EVALUATION**

1. Do you like the way your teeth look? Yes  No   
If no explain: \_\_\_\_\_
2. Are you happy with the color of your teeth? Yes  No   
If no, please explain: \_\_\_\_\_
3. Would you like your teeth to be whiter? Yes  No
4. Would you like your teeth to be straighter? Yes  No   
If yes, please explain: \_\_\_\_\_
5. Do you have spaces between your teeth that you would like closed? Yes  No
6. Would you like your teeth to be longer? Yes  No   
If yes, where: \_\_\_\_\_
7. Do you like the shape of your teeth? Yes  No   
If no, please explain: \_\_\_\_\_
8. Do you have missing teeth that you would like to replace? Yes  No
9. Do you have old silver fillings that you would like to replace with tooth colored fillings? Yes  No
10. If you could change anything about your smile, what would you change?  
\_\_\_\_\_

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Thank you for choosing us. All information you give us is strictly confidential and will not be released to anyone without written consent.

\_\_\_\_\_  
Signature (Patient, Parent, or Guardian)

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date