Scott I Rothbart DDS

1223 N. Providence Rd.
Media, PA 19063
(610) 566-5555
Fax: (610) 566-4499
www.DrRothbart.com

Date: _____ Social Security #: _____

Name: _____ Nickname: _____ Title: _____

Date of Birth:_____ Sex: Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ e-mail: _____

Please circle the best way to contact you: Home phone, Cell phone, Text, Business phone, e-mail

Emergency Contact: _____ Emergency Contact Phone: _____

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

Dental Insurance Information (*As a courtesy, we will try to file all claims for you*):

Are you the Primary Insured? Yes No If No: Primary Insured's Name: _____

Primary Insured Social Security #: _____ Primary Insured Date of Birth: _____

Primary Insured's Employer: _____

Insurance Company: _____Ins Co. Phone #: _____

Claims Address: _____

Medical History:

Circle any of the following which you have had or have and add additional information if necessary:

Artificial Joints _____	Hepatitis	Hemophilia
Artificial Heart Valve	Anemia	Sickle Cell Disease
Stroke	Rheumatic Fever	Excessive Bleeding / Bruising
Cancer Type _____	Kidney Disease	Headaches
Radiation	Ulcers	Seasonal Allergies
Chemotherapy	Liver Disease	Blood Transfusion
Congenital Heart Defects	Sjogren's Syndrome	Acid Reflux
Heart Failure	Emphysema	Drug / Alcohol Addiction
Heart Attack / Heart Disease	Tuberculosis	Smoking
Angina Pectoris	Asthma	Cold Sores
High Blood Pressure	Hay Fever	TMJ Disorder / Jaw Joint Pain
Heart Murmur	Diabetes	Sleep Apnea / Snoring
Mitral Valve Prolapse	Thyroid Disease	Sinus Issues
Scarlet Fever	Arthritis	Venereal Disease
Heart Pacemaker	Osteoporosis	Epilepsy / Seizures
HIV+	Glaucoma	Psychiatric Disease

Do you have any disease condition or problem not listed above? _____

Primary Physician Name: _____ Phone #: _____

Specialist: _____ Name: _____ Phone #: _____

Pharmacy: _____ Location: _____ Phone #: _____

Have you been hospitalized recently? Yes No If yes When?: _____ What for?: _____

Women:

Are you pregnant? Yes No

Are you nursing? Yes No

Do you think may be pregnant? Yes No

Do you use birth control prescriptions? Yes No

Medications:

Do you take any medications? Yes No List all below including over the counter, vitamins and mineral supplements:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to latex, penicillin, aspirin, codeine or another medication? Yes No

If Yes what are you allergic to? _____

What if any medications that causes a reaction to you, but is not allergic to? _____

Have you taken any bone loss prevention drugs such as Fosamax, Actonel, or Boniva? Yes No

If Yes which one and how often did you take it? _____

Dental History:

What is the reason for your visit today? _____

When was your last dental visit?_____

Who did you see for your last dental visit? _____

Where was that dentist located and may we contact the office? _____

What was your last dental visit for? _____

Have you been told that you need to take a premedication prior to dental treatment? Yes No

Are you anxious of today's visit or have you had anxiety for the dentist previously? Yes No

Did you ever have an upsetting dental experience? Yes No

Is there anything about your smile that you would like to change? Yes No

Would you like to keep all your teeth for your lifetime? Yes No

Are your teeth sensitive: to cold or hot? Yes No to sweets? Yes No to chewing? Yes No

Do you suffer from dry mouth? Yes No

Do you frequently get cold sores, mouth ulcers, or blisters? Yes No

Do you feel you grind or clench during the day? Yes No Anybody mentioned you grind or clench at night? Yes No

Do you gums bleed when you brush or floss? Yes No

Do your teeth feel like they are loose? Yes No

Has anybody told you that you have Periodontal disease or receding gums or receding bone levels? Yes No

Are you a mouth breather? Yes No

Is your breath as fresh as you would like? Yes No Any periods where you notice it's much worse than normal? Yes No

Have you had previous?

Orthodontics / Invisalign? Yes No

Oral Surgery / Wisdom tooth extractions Yes No

Periodontal therapy/ surgery? Yes No

Implant surgery? Yes No

Dentures/Partials you do not wear? Yes No

TMJ disorder therapy / Night Guard? Yes No

Clicking / Popping of jaw? Yes No

Difficulty opening or closing jaw? Yes No

I understand the above information is necessary to provide dental care in a safe and efficient manner, without it the dentist cannot actively treat my dental needs. I have answered all questions accurately and to the best of my knowledge. I will not hold anybody responsible for any action or lack of action due to errors or omission on this form. Should you need further information, you have my permission to contact any of my health care providers or agencies who may release additional information to you. I will notify this office of any changes in my health or medication list.

Patient or Guardian Signature:_____ Date:_____ Staff Signature:_____