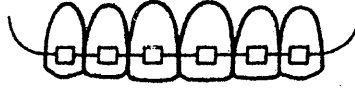


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Creating Generations of Smiles

Adult History Form for the Office of Marvin Rosenberg D.D.S.

Today's date: _____

General Information

Patient name: _____ Age: _____ Date of Birth: _____

Sex: Male Female Social Security #: _____

Address: _____ Cell () _____

_____ Tel. () _____
City State Zip

Marital status: Single Married Widowed Divorced Separated

Employer: _____ How long there? _____

Employer's Address: _____ Work Tel. () _____

Where and when are the best times to reach you? _____

Whom may we Thank for referring you? _____

Names of other family members seen by us? _____

Family Dentist: _____ Last Visit Date: _____

Family Physician: _____ Last Visit Date: _____

What are your concerns about your teeth? _____

Medical History:

Have you had or do you have any of the following?

- | | |
|---|------------------------------------|
| Y N Anemia | Y N Heart surgery / Pacemaker |
| Y N Artificial Bones / Joints | Y N Hemophilia / Abnormal Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma / Arthritis | Y N High / Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+ / AIDS |
| Y N Cancer / Chemotherapy | Y N Hospitalized for Any Reason |
| Y N Congenital Heart Defects | Y N Kidney Problems |
| Y N Diabetes / Tuberculosis | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug / Alcohol Abuse | Y N Rheumatic / Scarlet Fever |
| Y N Emphysema / Glaucoma | Y N Severe / Frequent Headaches |
| Y N Epilepsy/Seizures / Fainting Spells | Y N Shingles |
| Y N Fever Blisters / Herpes | Y N Sinus Problems |
| Y N Heart Attack / Stroke | Y N Ulcers / Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Your current general health is: Good Fair Poor

Y N Are you currently under the care of a physician? If yes, reason

Y N Are you currently taking any medication? If yes, describe

Y N Are you allergic to any medications? (E.g.: aspirin, penicillin, etc.) If yes,

Y N Have you ever had any general anesthesia? When?

For Women:

Y N Are you taking birth control pills?

Y N Are you pregnant? Week # _____

Y N Are you nursing?

Dental History:

Y N Have you ever had or a serious/ difficult problem associated with past dental work?

Y N Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ)?

Y N Do you clench / grind your teeth?

Y N Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Y N Do your jaw muscles ever feel tired? If yes, when _____

Y N Does it hurt to chew? If yes, when _____

Y N Do you hear clicking (popping) or grating sounds in your jaw joints?

Y N Have your jaws ever "locked" on you?

Y N Do you like your smile?

Y N Do your gums ever bleed? If yes, how often _____

Y N Have you ever had treatment for periodontal disease (gum disease)?

Y N Do you have any missing or extra permanent teeth?

Your current dental health is: Good Fair Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature Date

Thank you for filling out this form completely.

INSURANCE INFORMATION

Primary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____ / ____ / ____ Insured's SS #: _____

Insured's Employer: _____

Secondary:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relationship _____

Insured's Birthdate: ____ / ____ / ____ Insured's SS #: _____

Insured's Employer: _____