NAME _____
LAST FIRST MIDDLE

STREET _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____-_____-_____

SEX: MALE FEMALE STATUS: SINGLE MARRIED WIDOWED DIVORCED

TELEPHONE: (HOME) _____ ( WORK / CELL ) _____

eMAIL _____ FAX _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____

TELEPHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

All services are charged to the patient, I recognize that I am responsible for fees for services rendered regardless of insurance coverage. I understand I am responsible to pay actual and reasonable collection charges and/or attorney fees.

SIGNATURE: _____ DATE: _____

# PATIENT INFORMATION

**BARRY ROZENBERG DDS**
**1000 BROADWAY**
**WOODMERE, NY 11598**

**BARRY ROZENBERG DDS**
**18 E. 48TH ST**
**NEW YORK, NY 10017**

**BARRY ROZENBERG DDS**
1000 BROADWAY
WOODMERE NY, 11598

**BARRY ROZENBERG DDS**
18 E. 48TH STREET
NEW YORK, NY 10017

PATIENT NAME _____
LAST FIRST MIDDLE

PHYSICIANS NAME _____
ADDRESS/PHONE # _____
_____
DATE OF LAST VISIT _____

LIST CURRENT MEDICATIONS: _____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES?
PLEASE CIRCLE BELOW
ASPIRIN PENICILLIN CODEINE LATEX RUBBER ACRYLIC
OTHER: _____

DO YOU NEED PREMEDICATION PRIOR TO A DENTAL VISIT? YES NO
IF YES, WHY? _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO
IF YES, WHY? _____

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR INJURY? YES NO
IF YES, WHY? _____

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU WEAR CONTACT LENSES? YES NO

(*WOMEN*) PLEASE CIRCLE IF APPROPRIATE: TAKING BIRTH CONTROL PILLS
PREGNANT/TRYING TO GET PREGNANT NURSING

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| RHEUMATIC FEVER | ASTHMA | ARTIFICIAL JOINT |
| RHEUMATIC HEART DISEASE | DIABETES | SKIN RASH / HIVES |
| HEART MURMUR | FREQUENT URINATION | CORTISONE TREATMENT |
| MITRAL VALVE PROLAPSE | EXCESSIVE THIRST | HIV |
| PROSTHETIC HEART VALVE | HYPOGLYCEMIA | AIDS |
| IRREGULAR HEART BEAT | ANEMIA | GLAUCOMA |
| SHORTNESS OF BREATH | BRUISING | THYROID PROBLEMS |
| CHRONIC TIREDNESS | CANCER | BLOOD TRANSFUSION |
| CHEST PAIN / ANGINA | RADIATION THERAPY | CHEMICAL DEPENDENCY |
| HEART ATTACK | CHEMOTHERAPY | PSYCHIATRIC CARE |
| HIGH BLOOD PRESSURE | TUMOR OR GROWTH | COLD SORES |
| HIGH CHOLESTOROL | STOMACH ULCERS | SICKLE CELL DISEASE |
| STROKE | KIDNEY PROBLEMS | ARTHRITIS |
| SEIZURES / CONVULSIONS | RENAL DIALYSIS | ALLERGIES (MEDICINES) |
| FAINTING / DIZZINESS | TUBERCULOSIS | PARKINSONS DISEASE |
| HEADACHES | PERSISTENT COUGH | DRUG ADDICTION |

OTHER MEDICAL ISSUES NOT CIRCLED ABOVE: _____

SIGNATURE: _____ DATE: _____

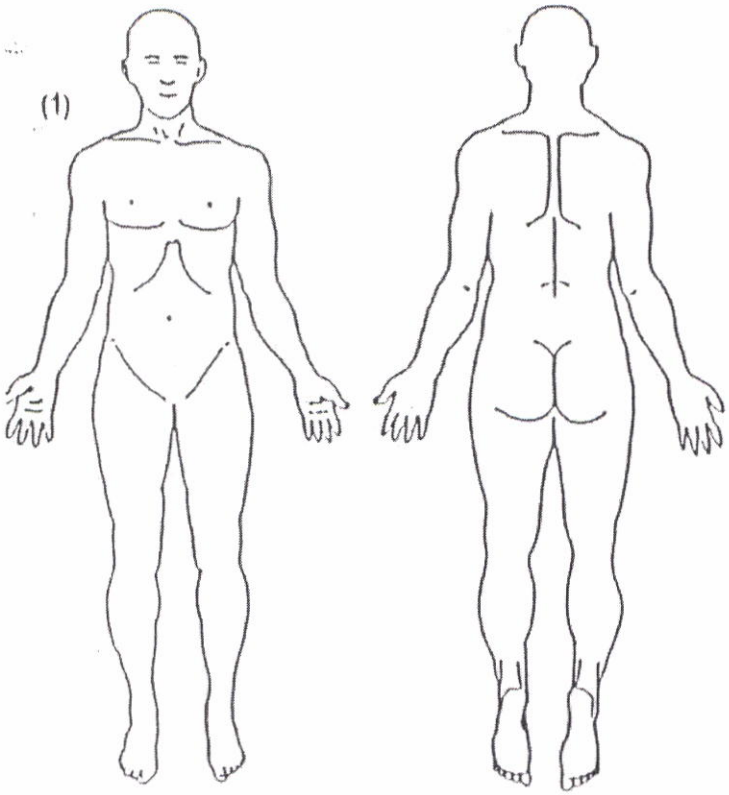
# MEDICAL HISTORY

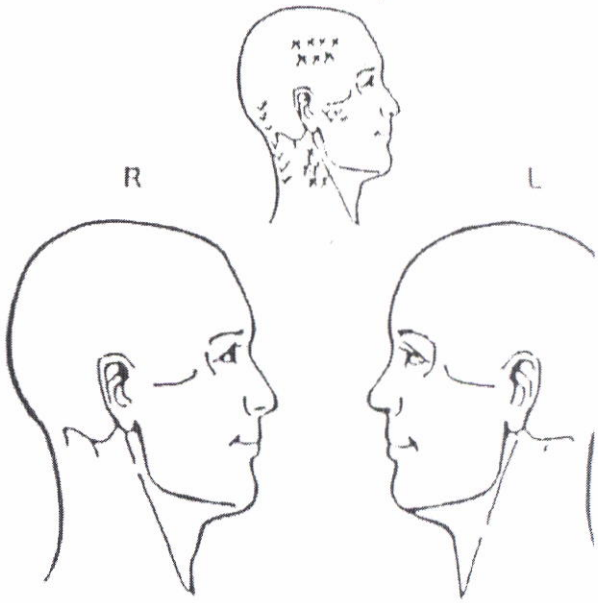
## Pain Location Chart

(1) Please draw the location of the areas that are painful; the most painful in bold x's, less painful in ✓✓✓.

As an example:

(1)





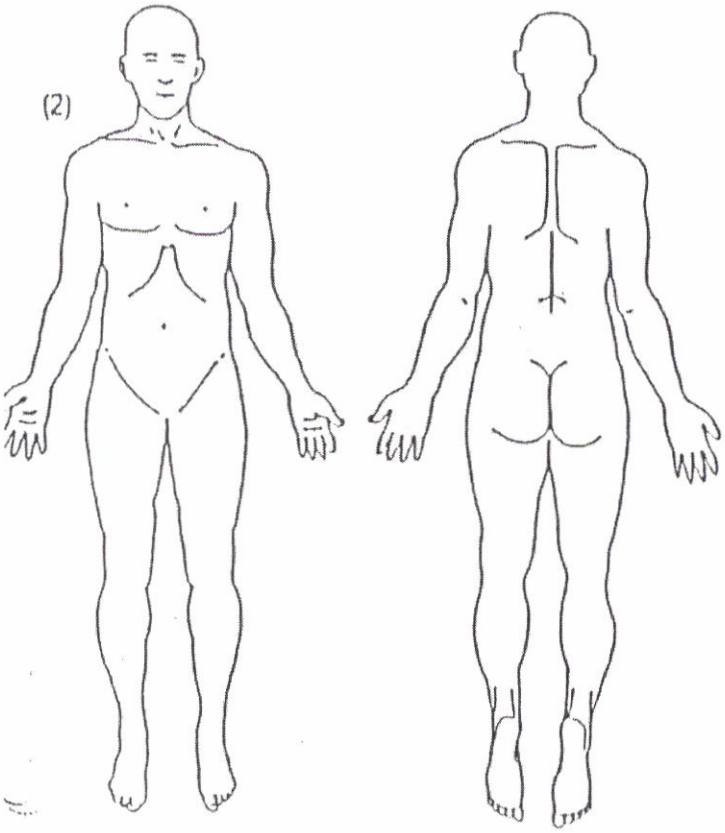

Approximate date of onset of

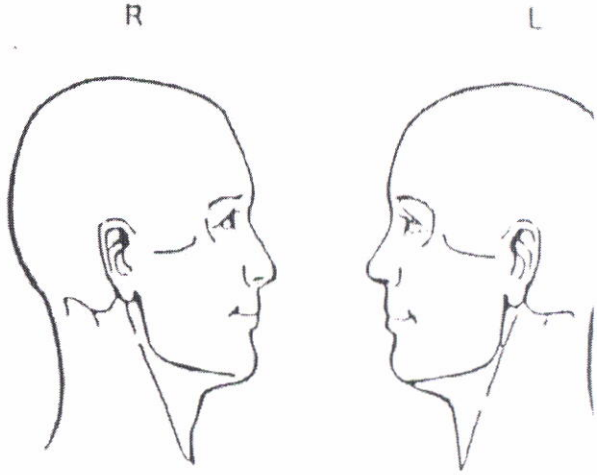
Most painful areas: _____

Less painful areas _____

(2) Please mark all areas that are numb with x's; that tingle with ✓✓✓; all scars with ++++

(2)






Approximate date of onset of

Numbness: _____

Tingling: _____

Dates of scars: _____

_____

Date: _____ Patient's signature: _____