BARRY ROZENBERG, D.D.S.
1000 Broadway
WOODMERE, N.Y. 11598
516 - 791 - 2200

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

MEDICAL HISTORY

BARRY ROZENBERG DDS
1000 BROADWAY
WOODMERE NY, 11598

BARRY ROZENBERG
18 E. 48TH ST
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: _____

DOCTOR LIST

Name:_____DATE:_____

If caused by an accident, describe briefly:_____
_____
_____
_____

Family Physician:_____
Address:_____
City:_____State:_____Zip:_____
Phone: ( )_____

Family Dentist:_____
Address:_____
City:_____State:_____Zip:_____
Phone: ( )_____

On the lines below, please list the doctors you have consulted for your complaint. Briefly describe their diagnosis, treatment and results. Be certain to include medication prescribed for you. Please bring copies of all available reports and x-rays.

Dr._____Phone:( )_____
Address:_____State:_____Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____Phone:( )_____
Address:_____State:_____Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____Phone:( )_____
Address:_____State:_____Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Dr._____Phone:( )_____
Address:_____State:_____Zip:_____
Specialty:_____ Date seen:_____
Diagnosis and treatment:_____
_____
_____

Briefly describe your problem:_____
_____
_____

What do you feel is the cause?_____
_____
_____

What do you hope to gain from treatment of your problem?_____
_____
_____
_____

BARRY ROZENBERG, DDS

OROFACIAL PAIN
TMJ DISORDERS

SLEEP APNEA
SNORING APPLIANCES

APPOINTMENT POLICY

We are committed to providing you with the highest quality care in the most efficient manner possible.

To ensure that you receive the highest quality treatment we schedule only one patient at a time.

When a patient has a scheduled appointment, there is much preparation that takes place well in advance of that time slot.

Our doctor wants to be available for your needs and the needs of all our patients.

When a patient does not show up for a scheduled appointment or does not call to cancel in advance, another patient loses the opportunity to be seen and, of course, the office loses production for that appointment slot.

Therefore any changes made within 24 hour of your appointment will incur a $100 fee.

Thank you for your understanding and cooperation as we institute this policy.

_____
Print Name of Patient / Guardian

_____ _____
Signature Date

1000 Broadway
Woodmere, NY 11598

516-791-2200

18 E. 48th Street
New York, NY 10017

877-863-1222

www.longislandcosmeticdds.net
www.tmj-painaway.com