

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/TRYPING TO GET PREGNANT NURSING

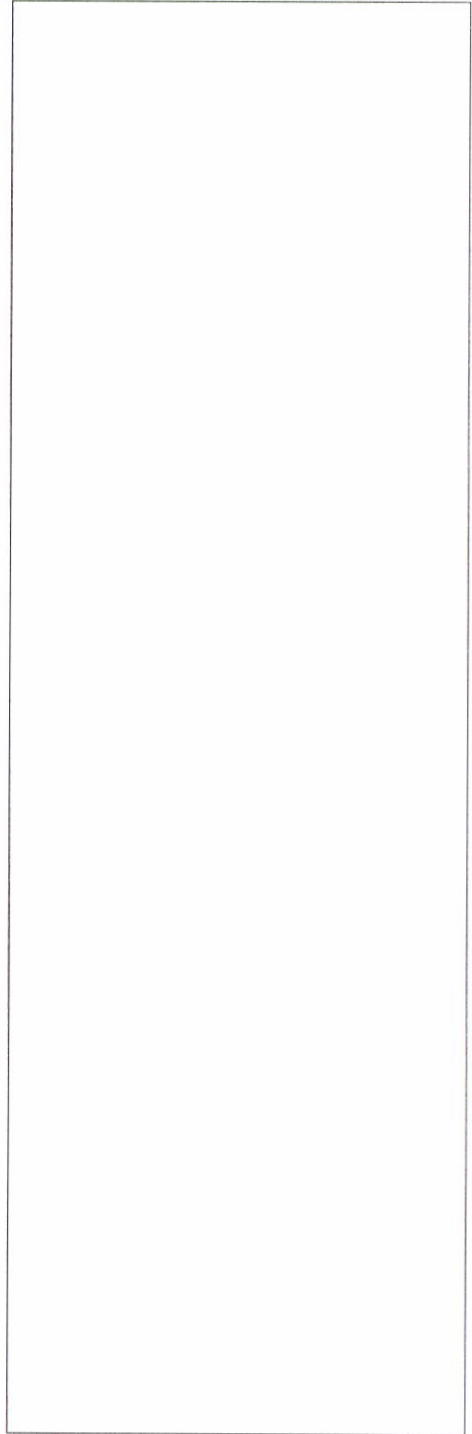
PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|-------------------------|--------------------|-----------------------|
| 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: _____

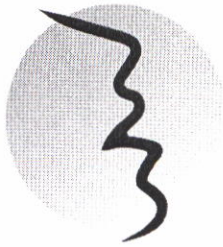
Dr. _____ Phone:() _____
Address: _____ State: _____ Zip: _____
Specialty: _____ Date seen: _____
Diagnosis and treatment: _____

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