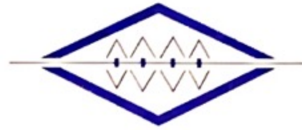

ROSENBERG ORTHODONTICS, PC

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Orthodontic Specialists

55 Town Line Rd., Wethersfield, CT 06109
(860) 529-9555

21 North Main St., West Hartford, CT 06107
(860) 236-1199

227 Albany Tpke., Canton, CT 06019
(860) 693-1919

435 Willard Ave., Newington, CT 06111
(860) 666-2009

PATIENT INFORMATION *for* **ADULT**

Patient's Name	Email	Home Phone		Cell Phone
Home Address		Town		Zip code
Age	Date of Birth	Sex	Marital Status	Name of Spouse
Employer	Address	Town/Zip code		Work Phone
Spouse's Employer	Address	Town/Zip code		Work Phone
Physician		Town/Zip code		Date of last exam
Dentist		Town/Zip code		Date of last cleaning

How were you referred to our office?

Reason for seeking orthodontic treatment?

Have you ever seen or been treated by another orthodontist? YES ❑ NO ❑

PATIENT MEDICAL HISTORY

How is your general health? ______________________

Have you ever had any of the following? *(please check yes or no)*

	YES	NO		YES	NO		YES	NO
Heart abnormality	❑	❑	Any operations?	❑	❑	Kidney/Liver problems	❑	❑
Rheumatic Fever	❑	❑	Diabetes	❑	❑	Cancer	❑	❑
Hepatitis	❑	❑	Cerebral Palsy	❑	❑	Hearing impairment	❑	❑
HIV+/AIDS	❑	❑	Do you take medicine?	❑	❑	Visual impairment	❑	❑
Tuberculosis	❑	❑	Allergies to medicine?	❑	❑	Frequent sore throats	❑	❑
Blood transfusions	❑	❑	Allergies to latex?	❑	❑	Earaches	❑	❑
Bleeding/Clotting problems	❑	❑	Tonsils/Adenoids removed	❑	❑	Respiratory problems/Asthma	❑	❑
Ever been hospitalized?	❑	❑	Convulsions/Epilepsy	❑	❑	If female: pregnant?	❑	❑

If you answered YES to any of the above questions, please explain:

Any other medical condition we should know about?

→ *Please turn form over and complete other side*

DENTAL HISTORY

(Please check yes or no)

	YES	NO	If you answered YES to any of the questions, please explain:
Have you ever had a difficult problem associated with previous dental work?	❑	❑	______
Any injuries to teeth, face or head?	❑	❑	______
Do you have TMJ problems, clicking or painful jaw?	❑	❑	______
Do you ever grind or clench your teeth?	❑	❑	______
Does your jaw ever lock upon opening or closing?	❑	❑	______
Do you floss your teeth?	❑	❑	______
Have you ever seen a periodontist for gum problems?	❑	❑	______
Have you ever seen an endodontist for root canals?	❑	❑	______

PAYMENT INFORMATION

(Person responsible for account)

Name ______ Social Security # ______

Billing Address ______ Town ______ Zip Code ______

Home Phone ______ Work Phone ______

Are you or your spouse employed by the U.S. Military or Reserve Corps? YES ❑ NO ❑

PRIMARY INSURANCE

Name of Insured	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES ❑ NO ❑	Orthodontic Coverage? YES ❑ NO ❑

SECONDARY INSURANCE

Name of Insured	
Insured's Social Security #	Insured's birthdate
Employer	Phone #
Employer's Address	Town/Zip code
Name of Insurance Company	Ins. Co. Phone #
Insurance Co. Address	Town/Zip code
Group or ID #	
Dental Coverage? YES ❑ NO ❑	Orthodontic Coverage? YES ❑ NO ❑

EMERGENCY INFORMATION

In the event of an emergency, is there someone we can contact?

Name ______ Relationship to Patient ______

Address ______ Town ______ Zip Code ______

Home Phone ______ Work Phone ______

I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct and I will notify you of any changes. I authorize the dental staff to perform the necessary dental services I may need. I understand and agree that I am financially responsible for the balance of my account and for any professional services rendered regardless of my insurance. I understand there is no charge for my initial evaluation; however, any orthodontic diagnostic records taken will be charged to my account.

Signature ______ Date ______