Patient Information

Donald R. Rozema, DDS, PC

Date _____

Male Female

Patient Name _____

Last First MI

Name I prefer to be called _____

Date of Birth _____ Social Security # _____

Phone (Home) _____ (Work) _____

(Cell) _____ (Other) _____

E-Mail address: _____

Preferred method of contact: _____

Address: _____

Street Apartment #

_____

City State Zip

Employer Name _____ Occupation _____

Address _____

Street City State Zip

Married Single Child Other

Spouse's Name_____ Work Phone _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Whom may we thank for referring you to our practice _____

Dental Insurance Information

Name of Insured _____

Insured Date of Birth_____ Social Security # _____

Insured Relationship to Patient Self Spouse Child Other_____

Insured Employer's Name_____

ID# _____ Group# _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Health History

Patient Name _____ Date of Birth _____

- ○ Heart Murmur (Mitral Valve Prolapse)
- ○ Artificial Joints: Hip Knee Other_____
  Please circle
  Date of surgery: _____
- ○ Rheumatic Fever
- ○ Take Diet Pills—Fen-Phen or other
- ○ Artificial Heart Valve
- ○ Infective Endocarditis
- ○ Congenital Heart Condition:
- ○ --unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
- ○ --a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter interventions, during the first six months after the procedure
- ○ --any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or prosthetic device
- ○ --a cardiac transplant which develops a problem in a heart valve.
- ○ Been told to **PREMEDICATE** before a dental procedure __Yes __No
  If yes, please explain:_____
  _____

- ○ Stroke
- ○ Heart (Disease, Surgery, Attack)
- ○ High Blood Pressure---What is your usual reading? ____/____
- ○ Blood Thinning Medication
- ○ Low Blood Pressure
- ○ Pacemaker
- ○ Pacemaker with a Difibulator
- ○ Stents
- ○ Abnormal Heart Condition

- ○ Respiratory Problems
- ○ Emphysema
- ○ Asthma
- ○ COPD
- ○ Sinus Problems

- ○ HIV Positive/AIDS Related Complex
- ○ Tuberculosis
- ○ Hepatitis: A B C Other_____
  Please circle
- ○ Jaundice
- ○ Liver Disease
- ○ Blood Transfusion Date: _____

- ○ Pregnant/Due Date: _____
- ○ Nursing Mother
- ○ Taking Birth Control Pills

- ○ Acid Reflux
- ○ Take Antiacids
- ○ Take Tagamet (Cimetidine)
- ○ Stomach Problems
- ○ Bowel Disorders
- ○ Eating Disorders _____
- ○ Arthritis
- ○ Rheumatiod Arthritis
- ○ Diabetes
- ○ Lupus
- ○ Sjogren's Syndrome
- ○ Other Autoimmune Disease:
  _____
- ○ Glaucoma
- ○ Blood Disorders
- ○ Abnormal Bleeding from a cut
- ○ Anemia
- ○ Fainting
- ○ Dizziness
- ○ Seizures
- ○ Epilepsy
- ○ Head Injuries
- ○ Nervous Disorders
- ○ Mental Disorders
- ○ Kidney Disease
- ○ Venereal Disease: List: _____
- ○ HIV Infection/AIDS
- ○ Recurrent Illnesses
- ○ Other Infections List: _____
- ○ Slow Healing Mouth Sores

- ○ Osteoporosis

- Hay fever
- Osteopenia
- Cancer Type: _____Date diagnosed: _____

Patient Name_____

Date of Birth _____

- Chemotherapy
- Radiation Therapy
- Oncologist Name and Phone number: _____
- Benign Growths/Tumors
- Previous Biopsies
- Sore/Enlarged Lymph Nodes

- Alcohol _____Drinks per week
- Tobacco:

__Cigarettes ___packs per day/week
Circle day or week
__Smokeless ___ cans per day/week
Circle day or week

- Illegal Drugs: _____
- Controlled Substance: _____ _____

Allergies:_

Codeine Penicillin LATEX Aspirin Valium Metal
Local Anesthetics or other sedatives
Please circle all that applies

Other Medications: _____
_____

Environmental: _____
_____

Foods: _____
_____

Do you take *or* have you ever taken any of the following medications:
Please list date you started *and/or* stopped the medication.

Actonel (risedronate sodium)
Dosage and frequency: _____ Start Date: _____ Stop Date: _____
Fosamax (alendronate)
Dosage and frequency: _____ Start Date: _____ Stop Date: _____
Boniva (ibandronate)

Dosage and frequency: _____ Start Date: _____ Stop Date: _____

Do you consume grapefruit juice, grapefruits, or grapefruit extract? Yes No
Patient Name _____ Date of Birth _____

Please list **ALL** current medications that you take. This includes all **Prescriptions**, **Over the Counter**, **Supplements,** and **Vitamins**. Please list the dosage and frequency.

_____

_____

_____

_____

_____

_____

Date of last health care exam:_____ What was it for? _____

Have you been admitted to a hospital or needed emergency care in the past five years?
__Yes __No If yes, please explain _____
_____
_____

Are you now under the care of a physician? __Yes __No
If yes, please explain _____
Name and phone number of any physician you are currently receiving care from:
_____
_____
_____

Do you have any health problems not previous listed or that need further clarification?
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment with out fail.

_____

Signature of patient, parent, or guardian **Date**

Dr. Donald R. Rozema **Date**

Dental History

Patient Name _____ Date of birth _____

Why have you made this dental appointment? _____

Are you aware of any problems? _____

_____

How long since your last dental appointment? _____

What was done at your last dental visit? _____

Date of your last Hygiene visit? _____

Previous Dentist's name _____ Phone # _____

Why did you leave your previous dentist? _____

- Have you lost any teeth or had any removed?..... YES NO
Why? _____
- Have they been replaced?..... YES NO
What were they replaced with? _____
Are you unhappy with the replacement?..... YES NO
If yes, explain: _____
Would you like to know about permanent replacements?..... YES NO
- Have you had complications with previous dental treatment?..... YES NO
If yes, explain: _____
- Do you clench or grind your teeth?..... YES NO
- Does your jaw pop or click?..... YES NO
- Have you experienced any pain or soreness in your face muscles or around your ear?..... YES NO
- Do you have frequent headaches or neck aches?..... YES NO
- Does food get caught in your teeth?..... YES NO
- Are any of your teeth sensitive to: Hot Cold Sweets Pressure
- Do your gums bleed or hurt?..... YES NO
- How often do you brush your teeth? _____
- When do you brush your teeth? _____
- Do you use dental floss?..... YES NO
- How often do you floss? _____
- Are any of your teeth loose, tipped, shifted, or chipped?..... YES NO
- Do you feel your breath is offensive at times?..... YES NO
- Have you every had gum treatment or surgery?..... YES NO
- Have you had orthodontic work?..... YES NO
- Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?..... YES NO
- What questions or concerns do you have?

Please check one box in each section

Name: _____

Date of Birth: _____

My mouth is very comfortable.
My mouth is moderately comfortable.
My mouth is uncomfortable.

I think the appearance of my smile is excellent.
I am satisfied with the appearance of my smile.
I would like to change my smile.
I am unconcerned about the appearance.

I will do whatever I must to keep my teeth.
I want to keep my teeth but only within a certain budget of time and money.
I am indifferent about keeping my teeth.

I have always done what was recommended to me.
I have not done what was recommended to me.
I have not had dentistry recommended to me.

I put dental care high on my list for myself
I put dental care low on my list.
I have never considered where I put dental care.

I think my present state of dental health is excellent
I think my present state of dental health is good
I think my present state of dental health is poor

Obstacles I see to having excellent dental care for myself ...

If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of pain, surgery, or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other

Donald R. Rozema, DDS, PC

CONSENT FOR CARE

1. I consent to the release of all information pertaining to discoveries during an examination, diagnostic procedures, or treatment to my insurance company for billing purposes; as well as to my physician, for coordination of my medical and dental care.

2. I authorize that x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Rozema, be made in order to make a thorough diagnosis and establish treatment needs. I understand that diagnosis and treatment may include a consultation with my physician, or other practice specialists. I authorize and consent for Dr. Rozema to choose and employ such assistance as needed to provide recommended treatment.

3. I understand it is my responsibility to advise Dr. Rozema's office of any changes in my contact or medical information before my next appointment.

4. I understand that the originals of my radiographs, photos and models are part of my permanent record at Donald R. Rozema DDS, PC. However, I may request copies or duplicates for a nominal fee.

FINANCIAL AGREEMENT

Thank you for choosing Dr. Rozema to provide your dental care. We are grateful that you have chosen our practice for your dental needs. Our philosophy in serving people is to be informative, honest and forthright with our patients, especially in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in regards to your financial obligations. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask.

DENTAL INSURANCE

As a courtesy we will gladly print your insurance form for you to file for reimbursement. To help you understand the limitations of some insurance coverage, please read the following.

• Please provide us with an insurance card and all of the information necessary to verify your coverage and to enable us to print the proper forms.

• Please understand that your insurance policy is a contract between you, your employer, or the insurance company. We are NOT a party to that contract. Our relationship is with you and not with your insurance company.

• You are responsible for all fees we charge, not what your insurance company allows or calls "usual, customary and reasonable". Allowable fees and covered services vary widely from company to company and even between policies within the same insurance company. Some services you need may not be covered services under your insurance plan.

• In appropriate cases we will help you file your medical insurance.

PAYMENT POLICY

Payment will be due at the time service is rendered unless special arrangements have been made in advance. We accept cash, personal checks, debit cards, Visa, MasterCard, Discover, American Express and Care Credit. For patients needing extensive treatment, we will review all fees in advance and arrange an appropriate payment plan if necessary.

MINOR PATIENTS

The adult accompanying a minor (under age of 18) is responsible for full payment of the services provided. A parent or legal guardian must accompany the minor when dental services are rendered unless prior arrangements have been made with our office.

RETURNED CHECKS

A $25.00 charge applies when a check is returned by the bank.

CANCELED APPOINTMENTS

We request 2 business days to re-arrange our scheduled if you need to cancel or change an appointment. There is a $100 fee that may be charged for appointments canceled less than 2 business days in advance.

FINANCE CHARGES AND COLLECTION FEES

I understand that all responsibility for payment of services provided by Dr. Rozema and staff for myself or my dependent(s) is mine. Payment will be due at the time service is rendered unless special arrangements have been made in advance. I understand a service charge of 1.5% per month (18% APR) or $8.00 whichever is greater, will be added to my account for balance due past 30 days. In event payments are not received, I understand collection action will begin and additional collection charges may be accrued. I understand and agree that information to assist in the collections of this account, should I default, may be given to an attorney, collection agency, or other professional contracted by the office.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you with the management of your account.

I have read and understand the above consent for care and financial policy information.

Form completed by:

Name_____ Date of Birth _____

Signature_____ Date_____

Reviewed by staff member ______________________________Date_______________________