NEW PATIENT INFORMATION

Patient's Name	Social Security Number	Age	Date of Birth	Marital Status
Address	Town	State	Zip Code	Home Phone
Patient's Employer	Occupation	How Long Employed?		Business Phone
Employer Address	Town	State	Zip Code	
Spouse's Name	Social Security Number		Spouse's Date of Birth	
Spouse's Employer	Spouse's Occupation			
Person Responsible for Payment?	Address & Telephone Number (if different from above)			
How Did You Hear About Dr. Rosenfeld?				
Name of Previous Dentist?	Reason for Leaving?			

MEDICAL HISTORY

Physician's Name and Address — Date of Last Physical Exam

Please list any medications you are taking:

Please check if you have or have had any of the following:

___Heart Problems	___Arthritis	___Psychiatric Care
___High Blood Pressure	___Asthma or Sinus Problems	___Nervous Problems
___Low Blood Pressure	___Allergies to Anesthetics	___Anemia
___Diabetes	___Allergies to Medications	___Excessive Bleeding
___Hepatitis		___Are You Pregnant?
___Radiation Treatment	___Allergies To _____	___Contact w/HIV Positive?

DENTAL INSURANCE INFORMATION

Name of Insured Person

Name and Address of Insurance Company

PAYMENT IS DUE AT TIME OF TREATMENT. PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL BALANCES SUBJECT TO A FINANCE CHARGE OF 1.5% MONTHLY.
CANCELLATION FEE MAY APPLY FOR A MISSED APPOINTMENT.
I AUTHORIZE RELEASE OF ANY INFORMATION TO A THIRD PARTY.
I AUTHORIZE DIRECT PAYMENT FROM THE INSURANCE COMPANY TO THE DENTIST.

Signature **Date**