



# ROSENBERG ORTHODONTICS, PC

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## Orthodontic Specialists

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

928 Farmington Ave., 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		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	<input type="checkbox"/>	<input type="checkbox"/>	Any operations?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>
HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex?	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoids removed	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	If female: pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any injuries to teeth, face or head?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have TMJ problems, clicking or painful jaw?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you ever grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your jaw ever lock upon opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you floss your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever seen a periodontist for gum problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever seen an endodontist for root canals?	<input type="checkbox"/>	<input type="checkbox"/>	_____

# 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 <input type="checkbox"/> NO <input type="checkbox"/> Orthodontic Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/>	

## 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 <input type="checkbox"/> NO <input type="checkbox"/> Orthodontic Coverage? YES <input type="checkbox"/> NO <input type="checkbox"/>	

# 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
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