



ROSENBERG ORTHODONTICS, PC

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(860) 529-9555

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(860) 693-1919

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

PATIENT INFORMATION for CHILD

| | | | | |
|--|---------------|---|---------------|------------|
| Child's Name | Nickname | Age | Date of Birth | Sex |
| Home Address | | | Town/Zip code | Home Phone |
| Mother's name | Address | Town/Zip code | Home Phone | |
| Mother's employer | Address | Town/Zip code | Work Phone | |
| Father's name | Address | Town/Zip code | Home Phone | |
| Father's employer | Address | Town/Zip code | Work Phone | |
| Names & ages of brothers & sisters | | | | |
| Child's Physician | Town/Zip code | Date of last examination | | |
| Child's Dentist | Town/Zip code | Date of last dental cleaning | | |
| How was your child referred to our office? | | Reason for seeking orthodontic treatment? | | |
| Has your child ever seen or been treated by another orthodontist? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |

PATIENT MEDICAL HISTORY

| How is your child's general health? | YES | NO | Has your child ever had any of the following? (please check yes or 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"/> |
| Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | Does patient 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"/> |
| HIV+/AIDS | <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)

- Has your child ever had a difficult problem associated with previous dental work? YES NO
- Does your child ever grind or clench his/her teeth? YES NO
- Is your child's water source fluoridated? YES NO
- Any injuries to teeth, face or head? YES NO
- Does your child have TMJ problems, clicking or painful jaw? YES NO
- Does your child have a history of thumb/finger sucking habits, tongue habits? YES NO

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

Current _____ Past _____ Until age _____

Who brushes your child's teeth? _____
When _____

PAYMENT INFORMATION

(Person responsible for account)

| | | | |
|-----------------|------------|-------------------|---------------|
| Name | | Social Security # | |
| Billing Address | Town | Zip Code | |
| Home Phone | Work Phone | Mother's Cell | Father's Cell |

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"/> | |

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 _____