Dr. Roni Rosati
DENTISTRY

3110 Highland Rd. Suite 202
Hermitage, PA 16148
724-981-0521
Fax: 724-981-9790

Patient Information

NAME____________________________

ADDRESS____________________________

____

HOME PHONE ____________________________

CELL PHONE ____________________________

WORK PHONE ____________________________

E-MAIL____________________________

DATE OF BIRTH ____________________________

SS# ____________________________

SPOUSE ____________________________

CHILDREN ____________________________

**REFERRED BY____________________________

EMERGENCY CONTACT

NAME ____________________________

PHONE# ____________________________

EMPLOYER NAME, ADDRESS AND PHONE#

____

____

____

PRIMARY DENTAL INSURANCE

INS.CO.____________________________

INS. ADDRESS____________________________

____

INS. PHONE #____________________________

GROUP#____________________________

ID#____________________________

SUBSCRIBER NAME ____________________________

SUBSCRIBER ADDRESS & PHONE____________________________

____

SUBSCRIBER RELATIONSHIP TO PATIENT____________________________

SUBSCRIBER D.O.B.____________________________

SUBSCRIBER SS#____________________________

SUBSCRIBER EMPLOYER NAME & PHONE #

____

SECONDARY DENTAL INSURANCE

INS.CO.____________________________

INS. ADDRESS____________________________

____

INS. PHONE#____________________________

GROUP#____________________________

ID#____________________________

SUBSCRIBER NAME ____________________________

SUBSCRIBER ADDRESS & PHONE____________________________

____

SUBSCRIBER RELATIONSHIP TO PATIENT____________________________

SUBSCRIBER D.O.B.____________________________

SUBSCRIBER SS#____________________________

SUBSCRIBER EMPLOYER NAME & PHONE #

____

PATIENT NAME___________________________

PATIENT MEDICAL HISTORY

PHYSICIAN___________________________

PHYSICAN PHONE #___________________________

ARE YOU UNDER DR'S CARE NOW? YES/NO

IF YES, FOR WHAT?___________________________

WOMEN: ARE YOU PREGNANT? YES/NO

MEDICATION ALLERGIES: ___________________________

DAILY MEDICATIONS: ___________________________

____

DO YOU HAVE OR HAVE YOU HAD:

YES NO

___ ___ MITRAL VALVE PROLAPSE

___ ___ HEART MURMUR

___ ___ HEART DISEASE OR ATTACK

___ ___ ARTIFICIAL HEART VALVE

___ ___ HIGH BLOOD PRESSURE

___ ___ LOW BLOOD PRESSURE

___ ___ PACEMAKER

___ ___ ANGINA

___ ___ STROKE

___ ___ ANEMIA

___ ___ RHEUMATIC FEVER

___ ___ ASTHMA

___ ___ EPILEPSY/SEIZURES

___ ___ CHEMOTHERAPY/RADIATION

___ ___ ARTHRITIS

___ ___ AIDS/HEPATITIS/STD'S

___ ___ DIABETES

___ ___ JOINT REPLACEMENT

___ ___ KIDNEY DISEASE

YES NO

___ ___ THYROID DISORDER

___ ___ VIRAL, HERPETIC, ORAL ISSUE

___ ___ DIGESTIVE ISSUES/ACID REFLUX

___ ___ MULTIPLE SCLEROSIS

___ ___ MUSCULAR DYSTROPHY

DO YOU SMOKE? ___________________________

DRUG/ALCOHOL ADDICTIONS ___________________________

OTHER MEDICAL ISSUES___________________________

____

____

DENTAL HISTORY

LAST DENTAL VISIT? ___________________________

PREVIOUS DENTIST___________________________

ARE YOU IN PAIN NOW? ___________________________

DO YOU HAVE ANY OF THE FOLLOWING?

YES NO

___ ___ LOOSE OR SORE TEETH

___ ___ BLEEDING GUMS

___ ___ ABSCESSES

___ ___ HEADACHES OR NECK PAIN

___ ___ DO YOU CLENCH OR GRIND

___ ___ SENSITIVE TEETH

___ ___ LOOSE FITTING DENTURES

___ ___ INTERESTED IN IMPLANTS

___ ___ INTERESTED IN TEETH WHITENING

HOW OFTEN DO YOU BRUSH? ___________________________

DENTAL CLEANING AIDS? ___________________________

OTHER DENTAL CONCERNS? ___________________________

SIGNATURE ___________________________

DATE___________________________