RDG
Rosenbaum dental group

Welcome to the Office of Rosenbaum Dental Group
2231 N. University Drive, Suite A, Pembroke Pines, FL 33024
(954) 981-5600 (ofc)

1

IF APPOINTMENT IS FOR *YOU*, START HERE

Date

Last Name First M.I.

Prefers to be Called By

Address

City State Zip

Phone Fax

Mobile Email

Birth Date Age ❒ Male ❒ Female

❒ Married ❒ Single ❒ Divorced ❒ Widowed

Social Security No.

IF APPOINTMENT IS FOR *YOUR CHILD*, START HERE

Date

Last Name First M.I.

Address

City State Zip

Phone

Birth Date Age ❒ Male ❒ Female

School Grade

Social Security No.

If Your Child's Last Name and/or Address are Not the Same as Yours, Fill in the Top Box Also

2

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No

SECONDARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No.

3

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?

Name

Relationship

You were referred to us by

Your former address

City State Zip

Person to contact for emergency

Phone

Address

City State Zip

Closest relative not living with you

Phone

Address

City State Zip

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Relationship to Patient

Social Security No.

Address

City State Zip

Phone

YOU

Name

Occupation

Employer's Name

Address City

Phone Fax

YOUR SPOUSE

Name

Occupation

Employer's Name

Address City

Phone Fax

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Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

1. **What is the reason for your visit today?** _____

_____

2. **What was done at your last dental visit?** _____

_____

Date of last dental visit_____ Last dental cleaning _____ Last x-rays _____

Previous dentist's name _____ Phone _____

Address_____ City _____ State _____ Zip_____

3. **How often do you have dental examinations?** _____

How often do you brush your teeth? _____ How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

_____

4. **Do you have any dental problems now?** ..... ❒ ❒

If yes, please describe:_____

Check "yes" or "no".	Yes	No		Yes	No
Are any of your teeth sensitive to:			**Have you experienced:**		
Hot or cold?	❒	❒	Clicking or popping of the jaw?	❒	❒
Sweets?	❒	❒	Difficulty in opening or closing the mouth?	❒	❒
Biting or Chewing?	❒	❒	Difficulty in chewing on either side of the mouth?	❒	❒
Have you noticed any mouth odors or bad tastes?	❒	❒	Pain? (joint, ear, side of face)	❒	❒
Do you frequently get cold sores, blisters or any other oral lesions?	❒	❒	Headaches, neckaches or shoulder aches?	❒	❒
			Sore muscles (neck, shoulders)?	❒	❒
Do your gums bleed or hurt?	❒	❒	**Have you ever had:**		
Have your parents experienced gum disease or tooth loss?	❒	❒	Orthodontic treatment?	❒	❒
Have you noticed any loose teeth or change in your bite?	❒	❒	Oral Surgery?	❒	❒
Does food tend to become caught in between your teeth? If yes, where?	❒	❒	Periodontal treatment?	❒	❒
			Your teeth ground or the bite adjusted?	❒	❒
Do you:			A bite plate or mouth guard?	❒	❒
Hold foreign objects with your teeth? (pencils, pipes, pins, nails, fingernails)	❒	❒	A serious injury to the mouth or head? If so, please describe, including cause:	❒	❒
Clench or grind your teeth while awake or asleep?	❒	❒			
Bite your lips or cheeks regularly?	❒	❒			
Mouth breathe while awake or asleep?	❒	❒			
Have tired jaws, especially in the morning?	❒	❒			
Smoke/chew tobacco?	❒	❒			

5. **Are you satisfied with your teeths appearance?** ..... ❒ ❒

6. **Would you like to keep all of your teeth all of your life?** ..... ❒ ❒

7. **Do you feel nervous about having dental treatment?** ..... ❒ ❒

If so, what is your biggest concern? _____

8. **Have you ever had an upsetting dental experience?** ..... ❒ ❒

If yes, please describe:_____

9. **Is there anything else about having dental treatment that you would like us to know?** ..... ❒ ❒

If yes, please describe:_____

1. Have you been under the care of a medical doctor and/or hospital during the past two years?
Y or N If yes, for what? _____
Physician's name_____ Phone_____
Address_____ City_____ State_____ Zip_____

2. Have you taken any medications or drugs during the past two years? _____
3. Are you taking any medications, drugs or pills now, including regular dosages of aspirin?
If Yes, Please List All: _____
_____
_____
4. Are you aware of having an allergic (or adverse) reaction to any medication or substance?
_____
5. Please indicate which of the following you have had, or have at present.

Circle "Yes" or "No"

AIDS/HIV Positive…….Y N	Emphysema……Y N	Nervious/Anxious…….Y N
Alzheimer's Disease…….Y N	Epiepsy or Seizures…… Y N	Psychiatric Care…….Y N
Anaphylaxis……..... Y N	Fainting/Dizziness…….Y N	Radiation Treatments…Y N
Anemia……....Y N	Heart Attack/ Failure…..Y N	Recent Weight Loss…... Y N
Arthritis……..…… Y N	Heart Murmur……...Y N	Rheumatic Fever……Y N
Artificial Heart Valve…… Y N	Heart Pacemaker…….Y N	Rheumatism..……..…... Y N
Artificial Joints……..…… Y N	Heart Trouble Disease. Y N	Shingles……. Y N
Asthma……. Y N	Hemophilia ……. Y N	Sinus Trouble.. ……. Y N
Blood Disease/Transfusion……Y N	Hepatitis A…..……. Y N	Sleep Apnea……..…. Y N
Breathing Problem …… Y N	Hepatitis B or C……Y N	Stomach/Intestinal
Bruise Easily……... Y N	High Blood Pressure… Y N	Disease……...…….Y N
Cancer…….…… Y N	High Cholesterol……...Y N	Sickle Cell Disease……. Y N
Chemotherapy……..….. Y N	Hives/Rash……Y N	Stroke……..……Y N
Chest Pains…… Y N	Kidney Problems……. Y N	Thyroid Disease ……..Y N
Cold Sores…….. Y N	Mitral Valve Prolapse... Y N	Yellow Jaundice……..Y N
Congenital Heart Disorder…… Y N	Osteoporosis……..….. Y N	
Convulsions….…… Y N		
Cortisone Medicine……..Y N		
Diabetes……Y N		

6. Do you have or have you had any disease, condition, or problem not listed?
_____
7. Are you pregnant? Y N / Nursing? Y N / Taking birth control pills? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.
Patient/Guardian Signature_____ Date _____

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Patient Screening Form

Date: _____

First Name:	Last Name:			
Birthdate:	Male ☐ Female ☐	Height:	Weight:	Neck Collar Size:
Can you breathe through your nose? Yes ☐ No ☐	Do you wear dentures? Yes ☐ No ☐			

HEALTH QUIZ

Do you snore?
Do you gasp or choke during sleep, witnessed or observed?
Do you feel sleepy, tired, fatigued, during the day?
Do you have high blood pressure or have treated it?
Do you have or are being treated for Diabetes?
Are you overweight?

EPWORTH SLEEPINESS SCALE

How likely are you to doze off to fall asleep in the following situation, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0=Never doze 1=Slight chance of dozing 2=Moderate chance of dozing 3=High chance of dozing

Chance of Dozing Score 0-3	Situation:
	Sitting and Reading
	Watching TV
	Sitting, inactive in a public place (i.e. movie theater or in a meeting)
	As a passenger in a car for an hour without a break
	Lying down to rest in the afternoon when circumstances permit
	Sitting and talking to someone
	Sitting quietly after lunch without alcohol
	In a car stopped for a few minutes in traffic

_____ TOTAL (This is your Epworth score)

SUMMARY:

You are at High Risk for Sleep APNEA if:	SLEEP HISTORY:
☐ You answer 2 or more on the health quiz OR	Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No
☐ Epworth sleepiness scale is 9 or greater OR	Do you currently have a CPAP machine? ☐ Yes ☐ No
☐ Combination 9 or more on Health Quiz OR Epworth Scale. Large	Do you use the CPAP less than 4 days a week? ☐ Yes ☐ No
☐ Neck size male >17 in Female >15 in.	Would you prefer an oral appliance? ☐ Yes ☐ No
	Do you wear a denture? ☐ Yes ☐ No

ORAL CANCER SCREENING

As a Healthcare provider, I continually review new medical technologies looking for those procedures that represent the latest advances in medical care for my patients. I have recently evaluated a new device and found that using it in conjunction with a conventional visual oral examination enhances my ability to identify, evaluate and monitor oral mucosal abnormalities (In plain English, I have the latest technology to help identify tissues that can be the precursors of oral cancer and I can find it earlier than I can see it with my naked eye.)

This painless, non-invasive visual test gives us a better chance to find any oral abnormalities you may have, at the earliest possible stage. This technology has successfully improved the identification of pre-cancerous abnormalities in thousands of exams of squamous epithelium of the cervix and has recently been cleared by the FDA for an oral application. Early detection of such abnormalities can result in the early treatment for pre-cancerous tissue. (Plain English… This technique has been used for many years to help detect early tissue changes in the lung cancer saving many lives by catching early)

This new device is called the VELscope and I am now offering it to all of my patients.
This exam is not a new procedure and insurance companies may cover some of the procedure cost however we will not be able to confirm your benefits.

For our records, please indicate below whether or not you wish to have the VELscope exam:

Yes please, I authorize my clinician to use the VELscope along with my conventional visual oral exam. I accept financial responsibility for this enhanced visual exam if the procedure is not covered under my insurance.
Print name:_____.

Signature: _____. Date: _____.

No thank you, I would prefer not to have the VELscope exam.
Print name:_____.

Signature: _____. Date: _____.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Ronald E. Rosenbaum, D.M.D., P.A., this ___ day of _____, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Please print your name

_____

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official, _____.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign
because (please describe) ____

_____

Signature of privacy official

STATEMENT OF OFFICE POLICY

Cancellation Policy

Our patients are reserved adequate time for their appointments to allow for the finest quality dental work. There is no non-emergency double booking, and we strive to stay on time. In order to be able to keep our fees at our present, reasonable levels; we must insist on at **least** 24 hours' notice for any cancellations.
* A minimum fee of $45.00 will be applied to your account, with an increase to $75.00 for appointments of 1 hour or more for missed appointments. Thank you for your understanding.
We understand that emergencies do arise from time to time. In these cases, the fee will be waived.

Financial Policy

Payment in full is expected when services are rendered. Procedures and fees are approximate for your dental care and subject to change at any time due to dental necessity. Certain procedures require a deposit ahead of time. Payment plans are available through our finance company. Balance billing is ***NOT*** an option. All other arrangements must be made ***PRIOR*** to scheduling appointments. Patient agrees to pay in full any balance that may end up on account within 15 days from receipt of the billing statement; any default of financial arrangement will result in a 1.5% interest charge from the date service was rendered.

Dental insurance may assist you with partial payment of your treatment. The ***ESTIMATED PORTION*** (your co-payment/ co-insurance) which is not covered is due when services are rendered.
Insurance Estimate is ***NOT*** a guarantee of payment. It is up to your insurance company to determine your dental benefits.
Patient is responsible for any service ***NOT*** covered by the insurance company.
We **will** file to your primary insurance for you; if your insurance has not paid within 60 days, you will be billed for the entire balance and payment in full will be expected at this time.
We **will** continue to work with you and your insurance company to expedite your reimbursement.
We do ***NOT*** accept assignment of benefits for secondary insurance; however, we will provide a claim form for you so that you may file and be reimbursed by the secondary insurance company.

Payment may be made by any of the following methods:
Cash, Personal or Business Check, CARE CREDIT, Visa, MasterCard, American Express & Discover.
Information is also available upon request for financing through Care Credit.

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance.
- I agree to have all insurance benefits for be paid directly to Dr. Rosenbaum.
- If the payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the check to Dr. Rosenbaum or make payment in full immediately to Dr. Rosenbaum.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement of any claims(s).
- If this account is assigned to an attorney or collection agency, I agree to pay attorneys fees, collection fees, court costs and interest from the date of treatment.

_____ _____

Signature of Responsible Party Date