FROM THE DENTAL OFFICE OF
SETH M. ROTH, D.M.D.

Welcome To Our Office ~ Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name:_____ ❑ Male ❑ Female

Address: _____City: _____State:_____ Zip: _____

SSN:_____ DOB: _____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ E-mail Address: _____

Employer:_____ Occupation: _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office: _____

What's your preference for an appointment confirmation via email or phone? If Phone, Check One ❑ Home ❑ Work ❑ Cell

May we call you at work for same day appointment availability calls? ❑ Yes ❑ No

■ INSURANCE - PRIMARY ■

Subscriber Name: _____ Relationship to Patient:_____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ INSURANCE - SECONDARY ■

Subscriber Name: _____ Relationship to Patient:_____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ ASSIGNMENT and RELEASE ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to the office of Seth M. Roth D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges **whether or not paid by insurance** as stated in our financial policy. I hereby authorize the doctor to release all information to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: _____ Your current health is ❑ Good ❑ Fair ❑ Poor

Physician's Name: _____ Physician's Phone:_____

Are you currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

_____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins, transplants joint replacements or implants placed? ❑ Yes ❑ No

Are you taking any medication? ❑ Yes ❑ No Please list each one: _____

_____

Have you had any surgical procedures? ❑ Yes ❑ No Please list each one: _____

_____

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Reason: ❑ Heart Murmur ❑ Mitral Valve Prolapse ❑ Artificial Knee or Hip ❑ Artificial Heart Valve

Sleep Isues

Have you been diagnosed with sleep apnea? ❑ Yes ❑ No Have you ever had an overnight sleep study? ❑ Yes ❑ No

Do you wake up in the morning with headaches? ❑ Yes ❑ No Do you or have you used a CPAP? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Have you been told that you gasp for air or suddenly stop breathing while sleeping? ❑ Yes ❑ No

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Crohns, Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis
❑	❑	Ulcers

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline

Yes	No	Female-Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you Pregnant? If so, # of Weeks _____
❑	❑	Are you nursing?

Nearest relative not living with you: Name: _____

Relationship: _____Addresss: _____Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest of confidence and its my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Dental History

How may we help you today?_____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? ❑ Yes ❑ No

Are you under stress? (new job, moving, relationship) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you'd like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

_____

_____

Here at the office of Seth M. Roth D.M.D. , we offer a wide variety of services to enhance and keep your smile beautiful.

Please check the services below you would like our staff to discuss with you during your visit.

❑ Kor®Deep Bleaching	❑ Veneers/Lumineers	❑ Gum treatment
❑ Opalescence Whitening	❑ Smile Makeover	❑ Bonding
❑ Short term orthodontics (Six Months Smiles)	❑ Crown and Bridge	❑ Implant Crowns
❑ Sealants	❑ Night/Sports Guards, NTI	❑ Bad breath
❑ Partials/Dentures	❑ Spaces between teeth or crowding	❑ Prevention of further problems
❑ Snoring or sleep apnea appliances		