WILLIAM E. ROCKSON D.M.D., P.C.
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PATIENT INFORMATION

Patient Name: _____ Today's Date _____

Gender (M/F): _____ Marital Status _____ DOB (mm/dd/yy): _____ SSN: ___ - ___ - ____

Driver's License Number: _____ E-mail Address: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____ Pager Phone #: _____

Address: _____ Fax: _____

_____ Other: _____

Best time and place to call: _____

Who may we thank for referring you? _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____ Gender (M/F): _____

Relationship to pt: _____ DOB (mm/dd/yy): _____ SSN: ___ - ___ - ____

Driver's License Number: _____ E-mail Address: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____ Pager Phone #: _____

Address: _____ Fax: _____

_____ Other: _____

INSURANCE INFORMATION

Primary	Secondary
Name of Insured: _____	Name of Insured: _____
Insured's DOB (mm/dd/yy): _____	Insured's DOB (mm/dd/yy): _____
ID Number: _____	ID Number: _____
Employer's Name: _____	Employer's Name: _____
Employer's Address: _____	Employer's Address: _____
Patient's Relationship to Insured:	Patient's Relationship to Insured:
⌗ Self ⌗ Spouse ⌗ Child	⌗ Self ⌗ Spouse ⌗ Child
Other: _____	Other: _____
Ins. Plan Name: _____	Ins. Plan Name: _____
Insurance Address: _____	Insurance Address: _____
Insurance Phone #: _____	Insurance Phone #: _____

I understand that I am ultimately responsible for the total costs of my treatment provided by William Rockson DMD and/or his staff, and/or for any finance or late fees that could result from delayed payments either from my insurance company or myself (1.5% per month on balances over 60 days/$25 dollars on payment agreements).

✖ CANCELLATION POLICY: ALL APPOINTMENTS REQUIRE 24 (TWENTY FOUR) HOURS NOTICE FOR ANY CHANGE. THERE WILL BE A CHARGE FOR ALL APPOINTMENTS CANCELED WITHOUT ENOUGH NOTICE.

HEALTH QUESTIONNAIRE

PHYSICIAN'S NAME: _____ Month and year of your last medical examination: _____

How would you describe your present health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Please check YES, NO or NOT SURE for the following questions. Make sure to answer ALL questions asked:

Yes	No	?	
☐	☐	☐	Has there been any change in your health in the past year? Describe: _____
☐	☐	☐	Have you had a serious illness, operation or hospitalization during the past five years?
☐	☐	☐	Are you taking any prescribed medications, if so please list: _____
☐	☐	☐	Over the counter, natural or herbal preparations: Please List: _____
☐	☐	☐	Have you ever taken Pondimin (Fendluramine), Phen-Fen (Phentermine) or Redux (Dephenfluramine) for weight reduction?
☐	☐	☐	Has your M. D. told you to take antibiotics prior to having any type of dental procedures?
☐	☐	☐	Are you **ALLERGIC** to any medications or drugs, latex, iodine?
☐	☐	☐	Have you ever had **ADVERSE REACTION** to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (motrin)? _____
☐	☐	☐	Have you ever had excessive bleeding that required special treatment?
☐	☐	☐	Have you been diagnosed as having any immunodeficiency, ARC or AIDS?
☐	☐	☐	Is there any history of diabetes in your family? If yes, who? _____
☐	☐	☐	Are you required, due to health, to restrict your work or activity in any way? How? _____
☐	☐	☐	Are you on a special or restricted diet of any kind? Describe: _____
☐	☐	☐	Do you use any kind of tobacco? If yes, how much, how often, for how long? _____
☐	☐	☐	Do you use any kind of alcohol? If yes, how much, how often and what kind of drink? _____
☐	☐	☐	Do you have any history of substance abuse? Describe: _____

FOR WOMEN, check all that area appropriate:

☐ I am pregnant ☐ I am nursing ☐ I am taking birth control pills

✘ **CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:**

- ☐ Chest pain upon exertion
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Valve Prolapse
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Lesion
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Damaged Heart Valve
- ☐ Heart Arrhythmia
- ☐ Tachycardia
- ☐ Heart Surgery
- ☐ Cardiac Pacemaker
- ☐ Heart Attack
- ☐ Hepatitis or Jaundice
- ☐ Blood Transfusion
- ☐ Impaired Liver Function
- ☐ Kidney Disease
- ☐ Impaired Kidney function
- ☐ Esophageal Reflux
- ☐ Hiatal Hernia
- ☐ G.I. Ulcers
- ☐ Anorexia or Bulimia
- ☐ Eating Disorder
- ☐ Diabetes
- ☐ Anemia
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Cancer
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus Troubles
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Angina
- ☐ Frequently Tired
- ☐ Joint Replacement Surgery
- ☐ Arthritis
- ☐ Connective Tissue Disorder
- ☐ Neurological Disorders
- ☐ Fainting/Seizures
- ☐ Stroke
- ☐ Headaches
- ☐ Migraines
- ☐ Epilepsy/Convulsions
- ☐ Mental Health Problems
- ☐ Glaucoma
- ☐ Wear Contact Lenses
- ☐ Severely Impaired Vision
- ☐ Recurrent Infections
- ☐ Sexually Transmitted Disease
- ☐ Thyroid Problem
- ☐ Chronic Fatigue
- ☐ Recent Weight Loss

DO YOU HAVE ANY DISEASE, PROBLEM OR CONDITION NOT LISTED ABOVE? PLEASE EXPLAIN: _____

DENTAL QUESTIONNAIRE

Name of Previous Dentist: _____

How frequently have you had your teeth cleaned during the past five years?

☐ Less than once per year ☐ 1 per yr ☐ 2 per yr ☐ 3 per yr ☐ 4 per yr

Last dental exam: _____ Last dental x-rays: _____

Are you presently satisfied with the condition of your mouth and teeth?
☐ Very Satisfied ☐ It's OK ☐ Somewhat dissatisfied ☐ Very dissatisfied

Yes	No	?	
☐	☐	☐	Do you presently have any pain, discomfort or impaired function related to your mouth? If yes, please. Describe: _____
☐	☐	☐	Are you currently aware of any infection in your mouth?
☐	☐	☐	Are you currently taking any antibiotics for infection? If so, what? _____
☐	☐	☐	Do your gums ever bleed? If so, when? _____
☐	☐	☐	Do you have a problem with bad breath or have any friends or family made you aware of this?
☐	☐	☐	Are you interested in replacing lost teeth?
☐	☐	☐	Do you ever have aches or pains in your jaw joints, ears, face, neck or head?
☐	☐	☐	Are any of your teeth tender when you chew hard foods?
☐	☐	☐	Are any of your teeth more sensitive to cold, hot, sweets, certain foods or drinks?
☐	☐	☐	Are any particular teeth very sensitive or painful? When?
☐	☐	☐	Are you concerned about gum recession around any of your teeth?
☐	☐	☐	Are you concerned about the appearance of your teeth or mouth?
☐	☐	☐	Have you ever had Orthodontic treatment? With Braces With removable appliances
☐	☐	☐	When did you go through Orthodontic care? How long? _____
☐	☐	☐	Have you ever received periodontal treatment? Scaling/Root Planing Gum Surgery
☐	☐	☐	When did you go through periodontal care? _____
☐	☐	☐	Do you have any sores or lumps in or near your mouth?
☐	☐	☐	Do you clench or grind your teeth?
☐	☐	☐	Have you ever had any prolonged bleeding following extractions?
☐	☐	☐	Do you wear dentures or partials? If yes, date of placement: _____
☐	☐	☐	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
☐	☐	☐	Do you like your smile?

I hereby authorize William Rockson DMD, and/or his staff to release any and all medical and dental information pertinent to my treatment to the previous named insurance carrier(s) for the purpose of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the A.D.A., and that it is the sole power and responsibility of; my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. The above information is accurate and complete to the best of my knowledge. I will not hold William Rockson DMD or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____

Signature of Patient or Patient's Legal Guardian Date of Signature

OFFICE POLICY

REGARDING PAYMENTS, TREATMENT AND APPOINTMENTS

1. **(A) CO-pays must be paid at the time of your visit or you will be rescheduled. (B) If you are more than 15 minutes late for your appointment, you will have to reschedule. (c)** If you have **s**ervices rendered that falls in the **Basic** or **Major** categories of your insurance plan and have an **applicable deductible or percentage co-payment**, **you must make that payment on the day of your treatment.**

   OUTSTANDING BALANCES MUST BE PAID IN FULL BEFORE FURTHER SERVICES ARE RENDERED.

2. **There is a fee for broken appointments**.

   This means if you **scheduled and confirmed** an appointment but failed to fulfill your commitment, **a $75.00 charge will be added to your account**.

   As a courtesy to us and other patients **please give** us at least **24-48 hrs** advance notice if you are unable to keep your appointment.

   Payment Options

   1. **Cash**--- includes money orders and personal checks.
   2. **Visa /MasterCard** --- we accept all major credit cards.
   3. **Care Credit**--- the monthly payment plan we offer as separate line of credit to cover you and your family member's healthcare needs. With Care Credit:
      - Approval usually only takes a few minutes
      - We offer No Interest Option: For example You can make monthly payments as low as 3% of the outstanding balance
      - We also offer low interest Extended Payment Plan options, for more time to pay your balance
      - No annual fees or prepayment penalties

3. If you do not have dental insurance, please notify the front desk staff upon arrival. **We will** be happy to **assist you** with applying for a healthcare card (With no interest & extended payment plans with flexible payment terms.

4. As a courtesy to you, we will file your insurance claims and send pre-determinations of benefits to your insurance carrier in order for you to be aware of your financial obligations towards your treatment.

   In an effort to expedite payment of your claims, please make inquiries to your insurance carrier(s) regarding status of your dental claims as we are only a third party entity. (Insurance contracts are between the patient, patient's employers and the insurance company).

5. We will accept your check only with **a valid driver's license** or **state issued ID.**
   If a check is returned to us due to insufficient funds, a returned check fee of $35.00 will be posted to your account along with the dollar amount of that check.

6. **In an effort to keep our records current, please inform us if there are any changes to your address, insurance carrier (s), emergency contact(s), or telephone number(s).**

Please help us to help you by adhering to the above policy. If there are any questions, comments, or concerns, please inform us of same.

Thank you.

I have read, understood and agreed to your office policies.
I understand that if I no longer wish to adhere to your office policies, I must notify your establishment in writing.
If I chose to have copies of my records transferred to another dental office, I have to pay any outstanding balance that I owe prior to my records being released.
I also understand that I am responsible for copying fees if applicable.

Patient's Name: _____
Patient's Signature: _____
Date: _____

(If patient is a minor)
Parents/ Guardians Name: _____
Parents / Guardians Signature: _____
Date: _____