Welcome

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glade to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date________________ Home Phone (______)____________________Cell Phone(________)______________

Name____ SS/HIC/Patient ID#_________________________

Last Name First Name Middle Initial

Address____ E-mail_____________________________

City____ State____________ Zip________________

Sex ☐M ☐F Age__________ Birthdate__________ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_______ years

Patient Employer/School______________________ Occupation___________________________

Employer/School Address_____________________________ Employer/School Phone(_____)_______________

Whom may we thank for referring you?____

In Case of emergency who should be notified?_____________________________ Phone(______)______________

Primary Insurance

Person Responsible for account____

Last Name First Name Middle Initial

Relation to Patient____________________ Birthdate________________ Id#/Soc.Sec.#__________________

Address(If different from patient)____ Phone (_____)______________

City____________________________ State_______________________ Zip __________________

Person Responsible Employed By____________________________ Occupation____________________

Insurance Company______________________________________ Contract #_____________________

Group #______________________________ Subscriber #______________________________________

Names of other dependents covered under this plan____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name__________________________ Relation to Patient_______________ Birthdate___________

Address (If different from patient)_____________________________________Phone(_____)_________________

City____ State_________________________ Zip_______________

Subscriber Employed by__________________________________ Business Phone(_____)________________

Insurance Company____________________________________ Soc. Sec.#__________________________

Contract #__________________________ Group#_________________________ Subscriber#_________________

Dental History

Reason for Today's Visit________________________________ Date of last dental care__________________________
Former Dentist____ Date of last dental X-rays _______________________
Check(√)☐ if you have had problem with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity to biting
☐ Sores or growths in mouth

How often do you floss? How often do you brush?

Medical History

Physician's Name____ Date of Last Visit________________

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe___________

Have you ever had a blood transfusion ☐ Yes ☐ No If yes, give approximate dates___________

(Women) Are you Pregnant ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills☐Yes☐No

Check (√) if you have or have had any of the following:

☐ Aids
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

If there are any changes in your medical history you must notify this office in writing.

MEDICATIONS:
List medications you are currently taking:
____

ALLERGIES:
☐Aspirin ☐ Barbiturates (sleeping Pills) ☐ Codeine ☐Latex
☐ Local Anesthetics ☐ Penicillin ☐ Sulfa ☐ Other__________

Facial & Cosmetic History

1. Have you ever had any Botox Procedures?
   ☐ Yes ☐ No
2. Have you ever had any dermal fillers such as Juvederm or Restylane?
   ☐ Yes ☐ No If yes please explain ___________________________________
3. Do you have any interest in having these procedures done?
   ☐ Yes ☐ No
4. Would you like a staff member to speak to you in regards to these procedures?
   ☐ Yes ☐ No

Doctor's Philosophy

Dr. Rosenblatt believes that a patient's overall health and well being is directly linked to the patient's dental health. His goal is to provide the highest quality of care in the fields of Periodontics as well as Implantology.

Dr. Rosenblatt treats each patient as an individual by first listening to his or her problems and then by customizing a treatment solution for each patient. "Warm, caring and professional" are the words most often used to describe both Dr. Rosenblatt and his staff.

Authorization

I certify that I, and/or my dependents(s), have insurance coverage with ______________________ and assign directly to
Name Of Insurance Company (ies)
Dr. __________________________ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________________
Signature Of Patient, Parent, Guardian of Personal Representative Date

____ ______________________________
Please print name of Patient, Parent, Guardian Or Representative Date

Payment is due In full at time of treatment unless prior arrangements have been approved

Dr. Gary M. Rosenblatt

187 Millburn Ave, Suite 2
Millburn N.J. 07041
Telephone: (973) 379-4100
Fax: (973) 379-5544

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ____, have received a copy of this Office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices. But acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify)

____
____
____

Gary M. Rosenblatt, D.M.D., F.A.C.D.
Practice Limited to Periodontics
** Implant Dentistry*
NJ Specialty #3046

187 Millburn Avenue
Millburn, NJ 07041
Telephone (973) 379-4100
Fax Number (973) 379-5544

Date: ___________________________________

I hereby authorize and request the performance of dental services for myself or for

____ Age: _______________

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or the supervised staff for diagnostic purpose or dental treatment.

I also give my consent For Gary M. Rosenblatt, D.M.D., F.A.C.D. to submit and accept payments from my Insurance Company on my behalf. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

I hereby acknowledge that no representation is made by Dr. Rosenblatt or any member of his staff as to complete satisfaction of the charges imposed for the services rendered from any dental insurance unless specifically provided in writing from the doctor on his letterhead.

Also, in the event that the account has to be turned over for collection, a service fee minimum of $30 or 30% of the total balance due will be added.

The office reserves the right to charge for missed or broken appointments with less than 48 hours notice.

Notice To All Patients:

The insurance companies are still requiring Patients and Policy Holders Social Security numbers for Electronic Billing. If you are unwilling to provide us with this information, you must pay for your visit at the time of service and submit the claim yourself for reimbursement.

____
Signature of Responsible Party

____
Relationship to Others Named