RICHARD H. ROLLMAN, D.D.S.
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Family, Preventive, Cosmetic,
and Implant Dentistry

Colonial Oaks Medical Arts Center
B-5 Cornwall Drive
East Brunswick, NJ 08816
Telephone: (732) 390-1911

PATIENT INFORMATION

Name:_____ Birth Date:_____ Soc. Sec. No_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Business Phone: _____

E-mail Address: _____ E-mail Appointment Confirmations (circle one): Yes No

Employer:_____ Occupation: _____

Business Address: _____

Financially responsible party or Insured (provide S.S. # & employer if different than above): _____

Dental insurance carrier, group #, and address: _____

Secondary insurance company, group #, and address: _____

Whom may we thank for referring you to our office? : _____

FAMILY INFORMATION

Husband (father)_____ Birth Date: _____

Wife (mother)_____ Birth Date: _____

Children_____ Birth Date: _____

_____ Birth Date: _____

_____ Birth Date: _____

MEDICAL INFORMATION

Physician's Name:_____ Date of last physical exam: _____

Do you have, or have you ever had, any of the following? Indicate with an X.

- ☐ Allergy to penicillin
- ☐ Allergies to other medications, latex, or metals
- ☐ Heart murmurs or heart ailments
- ☐ High blood pressure
- ☐ Neurologic or seizure disorders
- ☐ Radiation treatment
- ☐ Excessive bleeding from cuts or extractions
- ☐ Skin reactions to wearing jewelry
- ☐ Stroke
- ☐ Hay fever or allergies in general
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care &/or emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Diabetes (juvenile or adult onset)
- ☐ Heart valve or joint replacement surgery
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers or colitis
- ☐ Pregnancy? If so, what month?
- ☐ Venereal disease
- ☐ Arthritis
- ☐ AIDS/HIV positive
- ☐ Asthma
- ☐ Kidney Disorder

Describe any current medical treatment, including any medications taken, even if not listed above: _____

_____

_____

_____

DENTAL HISTORY

Chief oral complaint, if any: _____

Date of last dental visit: _____

Date of last intra-oral radiographs (x-rays): _____

Do you have, or do you use, any of the following? Indicate with an X.

- ☐ Teeth sensitive to cold, heat, sweets, or pressure
- ☐ Bleeding gums. How long?
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Burning sensation of tongue
- ☐ Swelling, bumps, or sores in mouth
- ☐ Frequent blisters on lips or in mouth
- ☐ Oral habits, i.e. fingernail biting, etc.
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experiences
- ☐ Complications from dental extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouthbreathing
- ☐ Limited opening of mouth
- ☐ Cigarette, cigar, or pipe smoking
- ☐ Texture of toothbrush:
- ☐ Frequency of brushing:
- ☐ Dental floss? How often?_____
- ☐ Fluoride supplements
- ☐ Electric brush or water jet device
- ☐ Pain around ears or neck
- ☐ Unusual sounds in either/both ears

Have you ever lost any teeth? _____

Were they replaced? _____

Describe your experience with the replacement: _____

How do you feel about the way your teeth look? : _____

Have you noticed any changes in your teeth such as spacing, drifting, color, wear, or chipping? If so, please describe:

_____

Do you have difficulty chewing food, opening or closing your mouth, or speaking? _____

Do both sides of your mouth touch evenly? _____

Please note any additional information that will enable us to best be of service to you:_____

_____

_____

_____

AUTHORIZATION

I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes I will inform the dentist.

I authorize my insurance company(s) to pay the dentist all insurance benefits otherwise payable to me for services rendered and authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of insurance benefits.

To avoid any misunderstanding, we wish our patients to know that all professional services rendered are charged directly to the patient, and that patient or their guardians are responsible for payment of all fees. Upon receipt of full or partial payment of your bill, depending upon arrangements made, we will prepare all the necessary forms &/or reports to assist you in receiving any insurance benefits. We do not provide services on the basis that insurance companies will always pay our entire fee. Our fees are set independent of any insurance carrier or coverage.

Signature:_____ Date: _____