STANLEY COHEN, D.D.S., P.A.

PATIENT INFORMATION

Patient's Full Name: ____________________________ Date of Birth: _________ Home Phone: (___)_________________

Marital status: ________________ Spouse name (if applicable):_______________________ Spouses work phone:_______

Address:____ City: __________________ State: ____ Zip: ________

Employer:____________________________ Occupation: _____________________ Work Phone: (___)________

Business Address: _______________________________ City: __________________ State: ____Zip: _________

Social Security #: _________________ Cell Phone #: ___________________________ School: ___________

How were you referred to this practice? ____

If you are completing these forms for another person, what is your relationship to that person? _________________

Person to notify in case of an emergency: __________________________________ Phone: (___)______________
Relationship of this person to you: _______________________________________

FINANCIAL RESPONSIBILITY

Is the patient financially responsible for this account? ________ (If yes, skip to insurance section of form)

Financially Responsible Party: _______________________ Relationship to the patient: _____________________

Address:________________________________ City: _________________ State: ________ Zip: _________

Home Phone: (___)______________ Employer: ____________________ Work Phone: (___)______________

INSURANCE INFORMATION

Is the patient covered by dental insurance? _______________ (If no, skip to medical history portion of form)

Policy Subscriber: ___________________________________ Insurance Company: ______________________

Subscriber's Address: ________________________________ Insurance Address: _______________________

____ _______________________________________

Relationship to patient: ______________________________ Insurance Group #: _______________________

Social Security #: _________________ Subscriber's Birth Date: ___________ Insurance ID #: _______________

Subscriber's Employer: ______________________ Employer's Address: _______________________________

If the patient also has secondary insurance coverage, please complete the following:

Policy Subscriber: ___________________________________ Insurance Company: ______________________

Subscriber's Address: ________________________________ Insurance Address: _______________________

____ _______________________________________

Relationship to patient: ______________________________ Insurance Group #: _______________________

Social Security #: ________________ Subscriber's Birth Date: ___________ Insurance ID #: ________________

Subscriber's Employer: ______________________ Employer's Address: _______________________________

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MEDICAL HISTORY

What is your impression of your present health (excellent, good, poor)? ___________________________________

Physician's name and phone number: __________________________ Year of last medical physical: __________

HAVE YOU EVER HAD OR DO YOU HAVE AT PRESENT? : (Please check to the right of each item)

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Heart Disease or Heart Condition				Blood Transfusion				Sexually Transmitted Disease (Syphilis, Gonorrhea)			
High or Low Blood Pressure				Sickle Cell Disease				AIDS or AIDS Related Complex			
Pacemaker				Other Blood Diseases				HIV Positive			
Angina Pectoris				Arthritis				Herpes			
Frequent Chest Pains				Asthma				Thyroid Disease			
Heart Attack				Sinus Trouble				Epilepsy or Seizure Disorder			
Shortness of Breath				Emphysema				Fainting or Dizzy Spells			
Swollen Ankles				Other Respiratory Diseases				Cold Sores			
Valve Disease				Tuberculosis				Jaundice			
Artificial Heart Valve				Diabetes				Hepatitis			
Congenital Heart Disease				Ulcers				Liver Disease			
Heart Murmur				Kidney Trouble				Sleep Apnea			
Rheumatic Fever				Implant Prosthesis				Drug/Alcohol Dependency			
Stroke				Frequent Headaches				Depression			
Bleeding Disorder				Joint Replacement				Radiation Therapy			
Bruise Easily				Cancer				Chemotherapy			
Prolonged/ Unusual Bleeding				Premedication for Dental Treatment				Neurological Problems			
Anemia				G.I. Tract Problems				Psychiatric Treatment			

Do you have any other medical problems not mentioned above? ______Please list___________________________

____

Have you had major operations? _____ Please list____

Are you allergic to any drugs/medications/materials (e.g., latex)? ___________ Please list______________________

Do you snore? Have you ever been told you snore? ____

What (if any) medications are you currently taking? (Include Birth Control Pills and Over the Counter Medication)

____

Do you smoke or use smokeless tobacco? ____________________ Are you wearing contact lenses? ___________

Women

Are you pregnant? _______________ If yes, what week? ________________ Are you nursing?__________

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DENTAL HISTORY

When was your last dental appointment? ____

Are you satisfied with the appearance of your teeth? ____________________________________

If not, what would you like changed? ____

Do you have any sensitive teeth? _______________________If yes, where? ____________________

Do you have any loose teeth? __________________________If yes, where? ____________________

Have you noticed any swelling, lumps or sores in your mouth? ______________If yes, where? __________

Do you have difficulty chewing your food? ______________If yes, where? _______________________

Do you have areas which break floss or where food lodges? ______________If yes, where? ___________

Have you had a toothache recently? __________________ If yes, where? _______________________

Do your gums bleed when you brush/floss? ______________________________________

Have you had orthodontic treatment (Braces)? ____________________________________

Have you had periodontal (Gum) treatment? ______________________________________

Do you grind, clench or grit your teeth?____

Are you aware of any clicking or popping in either TMJ (jaw joint)?___________________________

Do you experience any discomfort in either TMJ (jaw joint)?_________________________________

What type of toothbrush are you now using (soft, medium, hard)? ______________________________

Do you use dental floss? _________________________If so, how often? ____________________

When did you last receive instruction on proper cleansing of your teeth? ___________________________

Please list any dental concerns that you would like to bring to our immediate attention: ________________

____

Have you had any serious trouble associated with previous dental treatment? ______________________

What is the reason for today's visit? ____

What is your reaction to having dental treatment? Dread it _____ Worry about it ______ Don't mind it_____

I certify that the answers given are correct to the best of my knowledge. Furthermore, I understand that even though I may have some type of insurance coverage, I am financially responsible for services rendered. I hereby authorize release of any information regarding my insurance claims to my insurance company.

____ ____________________

Signature (Parent or guardian, if patient is a minor) Date

I hereby authorize payment of my insurance benefits directly to the office of Stanley Cohen, D.D.S., P.A.

____ ____________________

Signature (Parent or guardian, if patient is a minor) Date