**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 #: _________________ Drivers License #: ___________________________ 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: (___)______________

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 | | | | Unexplained Weight Loss | | | |
| 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______________________

Have you had local anesthesia (novocaine) before? ___________________________________________________

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? ____________________If yes, when? ______________________________

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 Stanley Cohen, DDS, PA.

_________________________________________________________ _________________________

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

Notes:___________________________________________________________________________________________

_________________________________________________________________________________________________