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

PATIENT INFORMATION (CHILD)

Patient's Full Name: ____________________________ Nickname: ____________ Date of Birth _______________________

Address:____ City: __________________ State: ____ Zip: _________________

Home Phone: (___)___________________________ School: ___________________
Grade:____________________

How were you referred to this practice? ____

When was your child's last dental appointment? __________________________ Hobbies/Favorite toys: _____________

Father

Name:____
Employer:_____________________________________
Work or Cell Phone: _____________________________
Social Security Number: __________________________
Birth Date: ______________________________________

Mother

Name: ____
Employer:_____________________________________
Work or Cell Phone:______________________________
Social Security Number: __________________________
Birth Date: ______________________________________

FINANCIAL RESPONSIBILITY

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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What is your impression of your child's health (excellent, good, poor)? ____

Physician's name:______________________________ Phone: (___)_________________________________

Has your child ever been treated for, or have you been told your child has, any of the following?

	Yes	No			Yes	No	
Heart Disease, Rheumatic Fever, or Heart Murmur				Psychological Problems			
Kidney or Urinary Tract Problems				Liver Disease (including Hepatitis)			
Respiratory Disease (including Asthma and Sinus Problems)				Diabetes			
Neurological Problems (including Seizure Disorders)				Arthritis or other Joint Problems			
Gastrointestinal Disease				Immunological Disease			

Please explain any items you have checked above____
____
Does your child have any other medical concerns not mentioned above? ____
____ Any hospitalizations/operations? __________________ Please explain____
Is your child allergic or sensitive to any drugs/medications/materials? _________ Please list____________________________
Has your child had local anesthesia (Novocaine) before? ____
What (if any) medications is your child currently taking? ____

DENTAL HISTORY

	YES	NO
Has your child experienced an unfavorable reaction from previous dental or medical care?	____	___
Has your child been living in an area where the water supply is fluoridated?	____	___
Has your child complained about dental problems?	____	___
Has your child had any unhappy dental experiences?	____	___
Has your child had any injuries to mouth, teeth, head?	____	___
Does your child have any oral habits such as thumb/digit sucking?	____	___
Is there an object (such as a blanket or toy) associated with this habit?	____	___
Does your child have any speech habits/concerns?	____	___
Does your child now wear (or has your child worn in the past) any orthodontic appliances?	____	___
Does your child brush his or her own teeth daily?	____	___
Is dental floss used?	____	___
Do you assist your child with oral hygiene?	____	___
Is a fluoride supplement taken in any form?	____	___
Do you have any specific concerns regarding your child's dental health?	____	___
Does your child snore?	____	___
Does your child grind their teeth?	____	___

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.

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Signature (Parent or Guardian) Date

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

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Signature (Parent or Guardian) Date