

**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

Mother

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Work or Cell Phone: \_\_\_\_\_

Work or Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

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: \_\_\_\_\_

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

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.

\_\_\_\_\_  
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.

\_\_\_\_\_  
Signature (Parent or Guardian)

Date