

**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 #: \_\_\_\_\_ E-mail \_\_\_\_\_

Contact preference: phone / e-mail \_\_\_\_\_

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

**Stanley Cohen, D.D.S., P.A.**

18109 Prince Phillip Dr., Ste 250  
Olney, MD 20832

Phone: (301)774-1020

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

**PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT**

We now offer the following payment options:

- ☐ Payment by cash
- ☐ Payment by check
- ☐ Payment by credit card
- ☐ Automatic monthly billing to your Visa or MasterCard.
- ☐ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

\_\_\_\_\_  
*Print your name here and sign below*

x \_\_\_\_\_

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

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