

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: _____

E-Mail: _____

E-Mail: _____

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: _____

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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.

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

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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