

**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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