



Stephen R. Cohen, DDS

PATIENT INFORMATION

Today's Date: _____

Patient: _____ Date of Birth: _____
Last First Middle Initial

How do you like to be addressed? _____

Gender: Male Female Social Security #: _____

Residential Address: _____
Street City State Zip Code

E-Mail Address: _____ Social Security No. _____

Home Tel. #: (_____) _____ Business Tel. #: (_____) _____

Cell #: (_____) _____ Fax #: (_____) _____

Employer: _____ Occupation: _____

Marital Status: Single Married Partnered

Spouse or Partner Name: _____

Who is legally responsible if other than patient? _____
Name

By whom were you referred? _____

Do you have dental insurance? Yes No

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Social Security #: _____

Address: _____
Street City State Zip Code

Home Tel. #: (_____) _____ Business Tel. #: (_____) _____

Relationship to Patient: Spouse Parent Guardian Other _____

Our office policy is that the parent or guardian who has requested treatment is responsible for all fees for services rendered.

Primary Insurance Information

Insurance Company Name and Address _____

Employee/Subscriber Name: _____ Social Security #: _____

Group # _____ Name of Employer with Telephone #: _____

Maximum Benefit for year: _____

EMERGENCY CONTACT

Person to contact in case of emergency: _____ Telephone: _____

Relationship to Patient: Spouse Parent Guardian Other _____

MEDICAL HISTORY

Please check YES or NO.

1. Do you have a current medical problem? YES NO
If yes, please describe, _____
2. Are you currently under the care of a physician? YES NO
If yes, please list, _____
3. Have you been hospitalized or had a serious illness within the past 5 years? YES NO
If yes, please describe, _____
4. Do you have heart trouble or any form of cardiovascular disease? YES NO
 - Angina (chest pains) Frequency _____ Rheumatic fever (date) _____
 - Heart attack (date) _____ Heart murmur
 - Heart surgery (date) _____ High blood pressure
 - Pacemaker Congenital heart lesions
 - Bypass Atherosclerosis
 - Prosthetic heart valve Mitral valve prolapse
 - Stroke (Date) _____ Other _____
5. Do you have diabetes? YES NO
6. Do you have any blood disease?
 - Anemia AIDS or positive test Leukemia Venereal disease Other _____
7. Do you have any problems with excessive bleeding? YES NO
If YES, Please explain, _____
8. Do you have stomach or intestinal ulcers? YES NO
9. Have you ever had tuberculosis? (Date) _____ YES NO
10. Do you have emphysema, asthma or breathing problems? YES NO
11. Do you have any form of arthritis? YES NO
 - Rheumatoid Arthritis Osteoarthritis Gout/Gouty Arthritis Other _____
 - Which joints are involved? _____
12. Have you had a hip or other joint replacement? YES NO
13. Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction) YES NO
14. Have you ever had any chronic head, neck, or back pain problems? YES NO
15. Have you ever suffered trauma to your head or neck, such as in a car accident? YES NO
If YES, please describe, _____
16. Do you have fainting spells, convulsions or epilepsy? YES NO
17. Have you had surgery, radiation or other treatment for a tumor or growth? YES NO
If YES, please describe, _____
18. Do you have glaucoma? YES NO
 - Right Eye Left Eye Both Eyes
19. Is your diet medically prescribed? YES NO
If YES, please explain, _____
20. Are you pregnant? (Expected delivery date) _____ YES NO

MEDICAL HISTORY (cont.)

21. Do you take aspirin on a daily basis? YES NO
22. Have you reached menopause? YES NO
If YES, what hormones are you taking, if any? _____
23. Are you taking any calcium supplementation? YES NO
24. Other concerns you may want the doctor to know about: _____

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

DENTAL HEALTH

- Reason for visit: _____
- When was your last dental visit? _____ With whom: _____ City & State: _____
- Have you ever had any serious problem associated with previous dental treatment? YES NO
- have you ever had any serious problem associated with previous dental treatment? YES NO
- If so, explain: _____
- How often do you brush your teeth on a daily basis? _____
- What texture brush do you use? Soft Medium Hard Nylon Natural
- Do you floss? YES NO How often? _____
- Do your gums bleed when brushing? YES NO
- Do your gums bleed when flossing? YES NO
- Do you avoid brushing any part of your mouth because of pain? YES NO
- If yes, what part? _____
- Do you feel twinges of pain when your teeth come into contact with:
- a) Hot foods or liquids, i.e. soup, coffee, tea, etc. ? YES NO
 - b) Cold foods or liquids, i.e. ice cream, cold fruit, etc. ? YES NO
 - c) Sweets, i.e. candy, fruit, sweet desserts, chocolates, etc. ? YES NO
- Do your gums feel tender or swollen? YES NO
- Do you clench or grind your teeth while sleeping or during the day? YES NO
- Do your jaws ever feel sore or tired? YES NO
- Do you wear: Dentures Retainers Night Guard Anti-Snore Device
- Would you or anyone in your family be interested in using an anti-snore device? YES NO
- Do you lose or break fillings easily? YES NO
- Do you gag easily? YES NO
- Are you familiar with "preventive dentistry"? YES NO
- On a scale of 1 to 5: How happy are you with your smile? (please circle) (not happy) 1 2 3 4 5 (very happy)
- How important are the cosmetics of your back teeth? (please circle) (don't care) 1 2 3 4 5 (really care)
- How much do you want to save your teeth? (please circle) (don't care) 1 2 3 4 5 (really care)
- Please add anything you feel is important: _____
- _____
- _____
- _____

MEDICATIONS

1. Are you taking any of the following medications?

- Sulfa drugs Xylocaine Other antibiotics _____ Nitrous oxide
 Codeine Epinephrine Aspirin Barbiturates Sleeping pills
 Any other medications _____
 Any drug allergies? _____

2. Have you ever been advised not to take a particular medication?

YES NO

If YES, please list _____

3. Have you ever been advised to take prophylactic antibiotics before dental treatment?

YES NO

4. Are you currently taking any medication?

YES NO

Please indicate any medications you are taking

	Name	Purpose	Frequency	Since
<input type="checkbox"/> Heart Medication				
<input type="checkbox"/> Blood Pressure Medication				
<input type="checkbox"/> Nitroglycerine				
<input type="checkbox"/> Inderal				
<input type="checkbox"/> Antibiotics				
<input type="checkbox"/> Sedatives				
<input type="checkbox"/> Tranquilizers				
<input type="checkbox"/> Pain Medication				
<input type="checkbox"/> Cortisone (Steroids)				
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Birth Control Pills				
<input type="checkbox"/> Other Medications				

5. Please indicate amounts, if any, of the following:

- Alcohol (_____) drinks per day
 Tobacco (_____) packs per day for approximately (_____) years
 "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor. _____

APPOINTMENT POLICY: Our practice is dedicated to your quality treatment and is pleased to reserve the appropriate amount of time for your appointment. A 48 hour notice is however required for any change in an appointment.

To the best of my knowledge, all preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature _____ Date _____