JOSEPH S. COHEN, D.D.S.

PATIENT INFORMATION

If this appointment is for you start here

First Name	Last	1
Name you wish to be called	Spouse's Name	
Social Security #	E-Mail	
Address		
City	State	Zip
Home Phone #	Cell Phone #	
Birthday	Age	
Married Single	Divorced Widowed	

If this appointment is for your child start here

First Name	Last Name
Nickname	
Address	
City	State Zip
Home Phone #	
Birthdate	Age Grade
School	

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS FILL IN THE ABOVE BOX ALSO.

2

GETTING TO KNOW YOU 2
Is another member of your family or relative a patient at our office?
Whom may we thank for referring you to our office?
In case of emergency, please list a friend or relative whose telephone is different than yours:
Name
Relationship
Phone Number

3

DENTAL INSURANCE 3		
PRIMARY CARRIER		
Insurance Company		
Address	City	State/Zip
Phone No.		
Policy Holder If Other Than Patient		
Policy Holder Social Security #	Date of Birth	
Relationship of Patient to Policy Holder Self Spouse Child Other		
Group/Local/Union #		
Agreement #/ID#	Date Employed	
SECONDARY CARRIER		
Insurance Company		
Address	City	State/Zip
Phone No.		
Policy Holder If Other Than Patient		
Policy Holder Social Security	Date of Birth	
Relationship of Patient to Policy Holder Self Spouse Child Other		
Group/Local/Union #		
Agreement #/ID #	Date Employed	

4

ACCOUNT INFORMATION 4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
Name
EXPECTED METHOD OF PAYMENT Check Cash Major Credit Card
PATIENT'S
Occupation
Employer
Business Phone
Business Address
YOUR SPOUSE:
Occupation
Employer
Business Phone
Business Address

I certify that the above information is complete and accurate.

✻ Patient Signature _____ Date _____

Patient Name: _____
First Last

HEALTH HISTORY

CIRCLE

1. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name _____

Address _____ Phone # _____

2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Are you having dental pain or discomfort at this time? ..... YES NO
4. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV/A.I.D.S.
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery	Infectious or Contagious Disease	Bruise Easily

5. Have you taken **any** medicine or drugs during the past two years? YES NO
   Are you now taking **any** medication, drugs or pills? ..... YES NO

   If yes, please list: _____

6. Are you allergic or have you reacted adversely to any of the following medications? ..... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic	Latex/Metal Products
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)	
Codeine	Tetracycline	Penicillin	Sleeping Pills	
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)	

7. Are you aware of being allergic to any other medications or substance ..... YES NO

   If yes, please list: _____

8. Do you have a family history of heart disease or diabetes? ..... YES NO
9. Do you have any disease, condition, or problem not listed? ..... YES NO
10. Are you on a special diet? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month.

Are you taking birth control pills? ☐ Yes ☐ No

I certify that the above information is complete and accurate.

*Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

ITIAL CONCERN _____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST FULL MOUTH SERIES OF X-RAYS

DO YOU HAVE ANY SPECIFIC DENTAL PROBLEMS NOW? ☐ YES ☐ NO

DO YOU HAVE ANY TEETH THAT ARE SENSITIVE TO HOT OR COLD? ☐ YES ☐ NO
SWEETS? ☐ YES ☐ NO

HAVE YOU EVER HAD:

a. ORTHODONTIC TREATMENT? ☐ YES ☐ NO

b. ORAL SURGERY? ☐ YES ☐ NO

c. PERIODONTAL TREATMENT? ☐ YES ☐ NO

d. ROOT CANAL TREATMENT? ☐ YES ☐ NO

e. YOUR TEETH GROUND OR THE BITE ADJUSTED? ☐ YES ☐ NO

f. WORN A BITE PLATE OR OTHER APPLIANCE? ☐ YES ☐ NO

4. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? ☐ YES ☐ NO

5. DO YOU EXPECT TO LOSE YOUR TEETH? ☐ YES ☐ NO

6. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH? ☐ YES ☐ NO

7. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? ☐ YES ☐ NO

8. DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR TEETH? ☐ YES ☐ NO

9. HAVE YOUR PARENTS EXPERIENCED GUM DISEASE? ☐ YES ☐ NO

10. PROBLEMS OF THE JAW. HAVE YOU EXPERIENCED:

a. CLICKING OF THE JAW? ☐ YES ☐ NO

b. PAIN (JOINT, EAR, SIDE OF FACE)? ☐ YES ☐ NO

c. DIFFICULTY IN OPENING OR CLOSING? ☐ YES ☐ NO

d. DIFFICULTY IN CHEWING? ☐ YES ☐ NO

11. HABITS. DO YOU:

a. CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? ☐ YES ☐ NO

b. BITE YOUR LIPS OR CHEEKS REGULARLY? ☐ YES ☐ NO

c. HOLD FOREIGN OBJECTS WITH YOUR TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? ☐ YES ☐ NO

d. MOUTH BREATHE WHILE AWAKE OR ASLEEP? ☐ YES ☐ NO

e. SNORE ☐ YES ☐ NO

f. EXPERIENCE DAYTIME SLEEPINESS? ☐ YES ☐ NO

12. DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT? ☐ YES ☐ NO

13. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE? ☐ YES ☐ NO

14. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? ☐ YES ☐ NO

15. WHAT CHANGES TO YOUR SMILE WOULD YOU LIKE?

_____

_____

16. IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT BOTHERS YOU? ☐ YES ☐ NO

EXPLANATION:

_____

_____

_____

_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

*Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Joseph S. Cohen D.D.S.
831 Haddon Ave
Collingswood, NJ 08108
856-854-5543

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers for my health care services**
- **Conduct normal health care operations such as quality assessment and improvement activities**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Joseph S. Cohen, D.D. S., F.A.G.D
Family Dental Care
831 Haddon Avenue
Collingswood, NJ 08108
www.drjosephcohen.com
856-854-5543

Photograph Authorization

I hereby give my consent for Dr. Cohen to take photographs, slides and/or videotape of _____(Patient's name) face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

Please initial:

_____I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing advertising, and laboratory use.
_____ I consent to the use of my photographs, slides, and/or videotape ONLY for laboratory use.
_____ I DO NOT consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taking in reliance on this authorization. Unless revoked by me, this authorization expires in 10 years for the date I sign below.

Patient's or Legal Guardian's/Representative's Signature **Date**

Dentist's Signature **Date**