Welcome!

Cohen | ORTHODONTICS

Please fill out this form completely to the best of your ability. The better we communicate, the better we can care for you. All patient records are kept strictly confidential.

Tell Us About Yourself

Today's Date: ______________

Name: ______________________________________
LAST FIRST MI

Prefer to be called: _______________ □Female □Male

Birthdate: _____/_____/_____ Age: _____________

SS#: _______-_______-_______

Home Address: ________________________________

____
CITY STATE ZIP

□Single □Married □Divorced □Widowed □Separated

Home #: (_____)___________________

Work #: (_____)___________________Ext. ________

Cell phone #: (_____)________________

Email address: ____________________________

Employer: ___________________________________

Occupation: __________________________________

When and where are the best times to reach you?_________

____

Whom may we thank for referring you?

____

Other family members seen by us: ___________________

General Dentist: _______________________________

Last Visit Date: ________________________________

Spouse's Name: ________________________________

Person Responsible for Account:

____

Work #: (_______)________________Ext. ____________

Home #: (_______)________________

Billing Address: ________________________________

Relationship: ___________________________________

SS #: _______________

Employer: ____________________

In the event of an emergency, who should we contact?

Name: ____

Work #: ________________ Home #: ______________

Primary Orthodontic Insurance

Insurance Co. Name: ___________________________

Insurance Co. Phone #: (______) __________________

Group # (Plan, Local, or Policy #): ________________

Policy Owner's Name: ___________________________

Relationship to Patient: __________________________

Policy Owner's Birthdate: _____/_____/_____

SS #: ________________

ID #: ________________

Medical History

Physician's Name: _______________________________

Phone #: (____)____________ Date of last visit: ___________

Please list any prescriptions/over-the-counter drugs that you are currently taking: ___________________________________

____

Please list all drugs/things that you are allergic to: ____________

____

For women, are you taking birth control pills? □ Yes □ No

Are you pregnant? □ Yes □ No Week #: ____________

Do you smoke? □ Never □ Seldom □ Frequently

Do you need to take antibiotics before getting your teeth cleaned at the dentist? □ Yes □ No

How often do you take NSAIDS?
(ex. Advil, Motrin, etc.) □ Never □ Seldom □ Frequently

Do you take any steroids? □ Yes □ No

Do you take a fish oil supplement? □ Yes □ No

Are you taking any medications for osteoporosis? □ Yes □ No

Do you take any Bisphosphonate medications (Fosamax, Boniva, Actonel, Didronel, Aredia, Skelid or Zometa)?
□Yes □ No

CONTINUED ON OTHER SIDE

Medical History continued

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints / Valves
Y N Asthma / Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy / Seizures / Fainting
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized For Any Reason
Y N Kidney / Liver Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Tuberculosis
Y N Sinus Problems
Y N Allergic to Latex
Y N Allergic to Metals / Plastics

Please list any serious medical conditions that you have or ever had:

____
____
____

Dental History

What are the main concerns that you would like orthodontics to accomplish?

____
____

Have you ever been evaluated for orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had any injury to your:
☐ Face ☐ Mouth ☐Teeth ☐ Chin
Explain:____________________________________
____
____

Do you now or have you ever experienced any pain/ tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for full payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein.

Doctors Comments: Initials:__________Date:__________

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