# 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 Heart Surgery / Pacemaker |
| Y | N | Anemia / Radiation Treatment | Y N Hemophilia |
| Y | N | Artificial Bones / Joints / Valves | Y N Hepatitis |
| Y | N | Asthma / Arthritis | Y N High / Low Blood Pressure |
| Y | N | Blood Transfusion | Y N HIV+ / AIDS |
| Y | N | Cancer / Chemotherapy | Y N Hospitalized For Any Reason |
| Y | N | Congenital Heart Defect | Y N Kidney / Liver Problems |
| Y | N | Diabetes | Y N Mitral Valve Prolapse |
| Y | N | Difficulty Breathing | Y N Psychiatric Problems |
| Y | N | Drug / Alcohol Abuse | Y N Rheumatic / Scarlet Fever |
| Y | N | Emphysema / Glaucoma | Y N Severe / Frequent Headaches |
| Y | N | Epilepsy / Seizures / Fainting | Y N Tuberculosis |
| Y | N | Fever Blisters / Herpes | Y N Sinus Problems |
| Y | N | Heart Attack / Stroke | Y N Allergic to Latex |
| Y | N | Heart Murmur | 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 been evaluated for orthodontic treatment in the past year? □ 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:_____

_____

_____