Print Form

Max J. Cohen, D.D.S
Sandra L. Cohen, D.D.S.

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointment, or fees, please feel free to ask. In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

Patient's Name _____ Birthdate _____ Today's Date_____
If Child, Parent or Responsible Party's Name _____Referred By _____
Address _____ Physician _____
City _____ State _____ Zip_____ Sex _____ Marital Status _____
Home Telephone _____ Cell Phone _____ Business Telephone_____
Your Social Security Number _____ Employed by (Occupation) _____
Name of Dental Insurance _____ Insurance I.D._____Group # _____
Insurance Company Telephone Number _____ Do you have any other Dental Coverage? _____
Spouse's Name _____ Bus. Tel. _____
Closest living relative not residing with you _____ Tel. No. _____
In case of Emergency, please Contact: _____ Phone Number _____
Nature of Present Dental Problem _____
Are there any procedures like replacement of missing teeth, cosmetics, veneering, bleaching, etc. that you would like to discuss?
_____
Have you had any serious trouble associated with any previous dental treatment? _____ If so, explain _____
_____

Medical History

1. Are you allergic to: Penicillin_____ Novocaine _____ Aspirin _____ Any other drug _____
2. Are you presently taking any drugs or medication (Include oral contraceptives & natural remedies)? _____
_____
3. Do you have any present illnesses (be thorough)? _____
_____
4. Do you have, or have you had any of the following diseases or problems: (Please select *Yes* or *No*)

Rheumatic Fever or Rheumatic Heart Disease	YES	NO	Hepatitis	YES	NO
Cardiovascular Disease	YES	NO	A. Jaundice	YES	NO
A. Heart Trouble	YES	NO	B. Liver Disease	YES	NO
B. High Blood Pressure	YES	NO	Stomach Ulcers	YES	NO
C. Low Blood Pressure	YES	NO	Tuberculosis	YES	NO
D. Arteriosclerosis	YES	NO	Goiter or Thyroid Disorder	YES	NO
E. Stroke	YES	NO	Convulsions Epilepsy or Seizures	YES	NO
F. Mitral Valve Prolapse	YES	NO	Psychiatric Disorders	YES	NO
Anemia or Blood Disorder	YES	NO	Drug or Alcohol Abuse	YES	NO
Asthma or Hay Fever	YES	NO	Prosthetic Joint Replacement	YES	NO
Allergies	YES	NO	Cancer	YES	NO
A. Seasonal	YES	NO	A. Chemotherapy	YES	NO
B. Food	YES	NO	B. Radiation Therapy	YES	NO
C. Latex	YES	NO	Sexually Transmitted Disease	YES	NO
Frequent Nose Bleeds	YES	NO	HIV or AIDS	YES	NO
Diabetes	YES	NO	Bleeding or Clotting	YES	NO
Arthritis	YES	NO	Kidney Disease	YES	NO

5. Are you presently under the care of any physician? _____
6. Have you ever been hospitalized (except for pregnancy)? _____ Are you pregnant? _____ Nursing?_____
   Have you ever had Major Surgery? _____ If so, what? _____
7. Last visit to a dentist _____ Type of treatment _____
   Dentist's name and address _____
   _____

Please Complete Next Page

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Regarding Insurance
We will file your insurance as a courtesy to you. Your insurance policy is a contract between you and your company: we are not a party to that contract. It is your responsibility to be aware of your insurance policies and coverage. If you have any questions regarding you insurance coverage we will do our best to assist you.

Usual and Customary Rates
Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

Payment is expected at time of service. Thank you for allowing us to serve you. All accounts are due upon receipt, and interest at the rate of 1.5% per month (18% A.P.R.) is charged on all balances over 30 days.

○ Payment after each visit ○ Credit Card (MC, Visa, Amex, or Discover)

Signature _____