Dr. Scott A. Cohen, D.D.S.

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Adult

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL NO.	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SS#	EMAIL		

Child

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2

DENTAL INSURANCE

PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO	

3

ACCOUNT INFORMATION	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY STATE ZIP	
PHONE NO.	

YOU	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

4

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME: RELATIONSHIP:
YOU WERE REFERRED TO US BY
YOUR FORMER ADDRESS
CITY STATE ZIP
PERSON TO CONTACT FOR EMERGENCY
PHONE NUMBER
ADDRESS
CITY STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU
PHONE NUMBER
ADDRESS
CITY STATE ZIP

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.