

PATIENT NAME
MEDICAL ALERT

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

## MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? .....Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? .....Yes No
3. Are you taking any medication, drugs or pills now? .....Yes No  
 If yes, please list name and dosage? \_\_\_\_\_
4. Have you ever taken prescription medications for weight loss (diet pills)? .....Yes No  
 If yes, did you take any of the following:
 

Yes	No	Fen-Phen (Fenfluramine-Phenpermine)
Yes	No	Pondimen (Fenfluramine)
Yes	No	Redux (Dexfenfluramine)

  
 If yes to any of the above, did you have a medical exam for heart issues? .....Yes No
5. Are you aware of having an allergic (**or adverse reaction**) to any medication or substance?.....Yes No  
 If yes, please list: \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years? .....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack).....Yes No	Ulcers..... Yes No	Hepatitis A (infectious) B (serum).....Yes No
Chest Pain.....Yes No	Diabetes.....Yes No	Venereal Disease.....Yes No
Congenital Heart Disease.....Yes No	Thyroid Problems.....Yes No	A.I.D.S. ....Yes No
Heart Murmur.....Yes No	Glaucoma.....Yes No	H.I.V. Positive.....Yes No
High Blood Pressure.....Yes No	Contact Lenses.....Yes No	Cold Sores/Fever Blisters.....Yes No
Mitral Valve Prolapse.....Yes No	Emphysema.....Yes No	Blood Transfusion.....Yes No
Artificial Heart Valve.....Yes No	Chronic Cough.....Yes No	Hemophilia.....Yes No
Heart Pacemaker.....Yes No	Tuberculosis.....Yes No	Sickle Cell Disease.....Yes No
Rheumatic Fever.....Yes No	Asthma.....Yes No	Bruise Easily.....Yes No
Arthritis/Rheumatism.....Yes No	Hay Fever.....Yes No	Liver Disease.....Yes No
Cortisone Medicine.....Yes No	Latex Sensitivity.....Yes No	Yellow Jaundice.....Yes No
Swollen Ankles.....Yes No	Allergies or Hives.....Yes No	Neurological Disorders.....Yes No
Stroke.....Yes No	Sinus Trouble.....Yes No	Epilepsy or Seizures.....Yes No
Diet (Special/Restricted).....Yes No	Radiation Therapy.....Yes No	Fainting or Dizzy Spells.....Yes No
Artificial Joints (hip, knee, etc.).....Yes No	Chemotherapy.....Yes No	Nervous/Anxious.....Yes No
Kidney Trouble.....Yes No	Tumors.....Yes No	Psychiatric/Psychologist Care.....Yes No
8. Do you use more than two pillows to sleep? .....Yes No
9. Have you lost or gained more than 10 pounds in the past year? .....Yes No
10. Do you have or have you had any disease, condition, or problems not listed? .....Yes No  
 If yes, please list: \_\_\_\_\_
11. **Women.** Are you:   **Pregnant?** Yes, \_\_\_\_\_ Months No           **Nursing?** Yes No           **Taking birth control pills?** Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>History Review</b>	
Dentist Signature _____	Date _____

PATIENT NAME
MEDICAL ALERT

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

## DENTAL HISTORY

*Welcome! So that we may provide you with the best possible care  
please complete both sides of this medical/dental history form.  
All information is completely confidential.*

**What is the reason for your visit today?**

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**Date of Last Dental Visit** \_\_\_\_\_ **Last Dental Cleaning** \_\_\_\_\_ **Last Full Mouth X-rays** \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**How often do you have dental examinations?** \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Interplak, toothpick, etc. ) \_\_\_\_\_

**Do you have any problems now?**    Yes    No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

**Do your gums bleed or hurt?**    Yes    No

Have your parents experienced gum disease? or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

**Do you:**

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

**Have you ever had:**

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

**Have you experienced:**

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)	Yes	No

**Are you satisfied with your teeth's appearance?**

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment? If so, what is your biggest concern?	Yes	No
Have you ever had an upsetting dental experience? If yes, please describe _____	Yes	No

**Is there anything else about having dental treatment that you would like us to know?**    Yes    No

If yes, please describe \_\_\_\_\_

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# Dr. Scott A. Cohen, D.D.S. PATIENT REGISTRATION

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	
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

<b>PRIMARY CARRIER</b>	
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.	

## Child

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

**3**

ACCOUNT INFORMATION	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY STATE ZIP	
PHONE NO.	
<b>YOU</b>	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.
<b>YOUR SPOUSE</b>	
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:
<b>YOU WERE REFERRED TO US BY</b>	
<b>YOUR FORMER ADDRESS</b>	
CITY	STATE ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>	
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 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_