Today's Date ______________

Patient Registration

Last Name ____ **First Name** ______________________________ MI ______

DOB __________ **Age** ______ **Sex** (please circle) **M** or **F** **SSN** ____________________ Please circle one: Single Married Separated Widow

Mailing Address ____ **City** ____________________ **State** _______ **Zip** ___________

Email _______________________ **Primary Phone** (_____)_______________ **Home Phone** (______)___________________

Primary Insurance Co ______________________ **Secondary Ins Co** __________________________ **Insurance cards must be provided***

Employer ____________________________ **Occupation** __________________________ **Work Phone** (______)__________________

If patient is a minor: Name of Parent ____ Parent DOB______________________

Parent Phone (_____)____________ Person Responsible for Account ___________________ Relationship __________________________

Emergency Contact ____________________________ Emergency Contact Phone Number (_______)________________________

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name ____ Relationship ____

Is this patient capable of making their own medical decisions? If not, are you able to on their behalf?

____

Is the patient their own legal guardian? If not, you must provide us with Guardianship Papers ***and*** DPOA (Durable Power of Attorney) prior to appointment time.

Guardian name: ____ **Guardian Phone #** (________)_______________________

Where did you hear about us? (Please Circle)

Google/Yelp Practice Website Facebook Family/Friend/Coworker Internet Other

Who can we thank for your visit? ____

Dental History

On a scale of 1-5, with 5 being the highest rating:

How important is your dental health to you? 1 2 3 4 5

Where would you rate your current dental health? 1 2 3 4 5

What would you like to change about your smile? (Circle any that apply)

Color Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

What is the most important thing to you about your future smile and dental health?____

____

What is the most important thing to you about your dental visit today?

____

____

Name of your previous dentist ____

Today's Date ______________

Dental History Continued (Please circle any and all of the following conditions that apply to you)

Appearance
Discolored teeth
Worn teeth
Misshaped teeth
Crooked teeth
Spaces
Overbite
Flat teeth

Pain/Discomfort
Sensitivity (hot,cold,sweet)
Pressure
Broken teeth/fillings
Worn Teeth
Dry Mouth

Function
Grinding/Clenching
Headaches
Jaw Joint (TMJ) pain/popping
Bad Bite
Speech Impediment
Mouth Breathing
Difficulty Opening/Closing
Difficulty Chewing

Periodontal (Gum) Health
Bleeding/Swollen Gums
Bad Breath
Loose tipped, shifting teeth
Previous perio/gum disease

Habits
Thumb Sucking
Nail-biting
Cheek/Lip Biting
Chewing on ice/foreign objects

Sleep Pattern or Conditions
Sleep Apnea
Snoring
Daytime Drowsiness
Bed wetting (for children)

Social
Tobacco use
Alcohol Frequency ________
Drug Frequency __________

PREVIOUS COMFORT OPTIONS
Nitrous Oxide
Oral Sedation (Pill)
IV Sedation

Please list all current medications

____
____
____
____
____
____
____
____
____
____

Medical History (Please circle your response to indicate if you have or have had any of the following)

Cancer
Type________________
Chemotherapy
Radiation Therapy

Cardiovascular
Angina (chest pain)
Artificial Heart Valve
Heart Conditions
Heart Surgery
High/Low Blood Pressure
Mitral Valve Prolapsed
Stroke
Pacemaker
Rheumatic Fever
Scarlet Fever

Endocrinology
Diabetes
Hepatitis A/B/C
Jaundice
Kidney Disease
Liver Disease
Thyroid Disease

Respiratory
Emphysema
Asthma
Sinus Issues
Tuberculosis

Musculoskeletal
Arthritis
Artificial Joints
Rheumatoid Arthritis

Mental
Autism Spectrum
Anxiety
Depression
Dizziness
Drug/Alcohol Addiction
ADD/ADHD
Intellectual Disabilities
Seizures
Psychiatric Illness

Viral Infections
AIDS
HIV Positive
HPV

Medical Allergies (circle any that apply)
Antibiotics (Penicillin/Amoxicillin/Clindamycin)
Opioids (Percocet, Oxycodone, Codeine)
Latex
Local Anesthetics
Other ____

Please list any physical/mental disabilities
____
____

Have you had any serious illness, operation, or hospitalization in the past 5 years?
____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, please list all.
____

Do you or have you ever been told to take any pre-medication antibiotic for dental procedures? (ie artificial joints, rheumatic fever)
____

Consent

The undersigned hereby authorizes Seth J. Cohen DDS LLC to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions. I certify that I have read and understand the questions asked in this Patient Registration and Medical History section on this form. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Sign here:____ **Date:**___________________________

Signature of Patient/Legal Guardian