Larry J. Cohen , D.D.S.

Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell Phone):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Pharmacy: _____ _____ **EMAIL** _____
Name Number

Address: _____
Street City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ Aspirin Daily
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/MVP
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Latex Allergy
OTHER:
☐ _____
☐
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain_____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Emergency Contact: _____Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Insurance Co. ☐ 1-800 Dentist ☐ Website ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between the provider and the patient.

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in the collection of your account.

I authorize the staff to provide any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the section at the bottom of form.

Patient Name_____

☐ **1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ Bridges_____ Crowns_____ Extractions_____ Impacted teeth removed _____ General Anesthesia_____ Root Canals_____ Other _____

(Initials_____

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swellin tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____

☐ **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while workin the teeth that were not discovered during examination, the most common being root canal therapy following routine restor procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____

☐ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatme understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of fe in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fract jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatn the cost of which is my responsibility.

(Initials_____

☐ **5. CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand t may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on unti permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape size, and color) will be before cementation.

(Initials_____

☐ **6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing th appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to n changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not includ the initial denture fee.

(Initials_____

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the succes the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatr (apicoectomy).

(Initials_____

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my te Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee resu acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfacti consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

I_____authorize the assignment of dental benefits paid directly to Dr. Larry Cohen.

_____ _____

Signature Date

I understand that my dental benefits may incur co-payments depending on dental work that is needed to be done. Most (not all) insurances will only cover 50% of all major work (example: post and crowns). If you have any questions regarding your insurance, now is the time to inquire, please do not wait until after you receive a bill to discuss your insurance issues.

_____ _____

Signature Date