Cohen & Cohen, D.D.S., P.A.

Patient Information

Patient Name: _____ Date: _____
Legal Last, Legal First MI (Chosen first name, if different)

☐ Male ☐ Female ☐ Other/prefer not to say
☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Email: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Name of next of kin/emergency contact person _____ Phone _____

How did you hear about our practice? _____

Reason for today's visit: _____ Date of Last Dental Visit: _____

Please indicate if you are allergic to any of the following substances:

___ Latex ___ Iodine ___ Penicillins ___ Sulfa drugs ___Other: _____

___ Codeine ___ Acrylic ___ Local anesthetic

Please list all medications you are taking (prescription, over-the–counter or herbal): _____

_____

Are you on a special diet? Y / N If yes, please explain _____
Women: **Pregnant?** Y / N **Trying to get pregnant?** Y / N **Taking oral contraceptives?** Y / N
Do you have a history of tobacco use? Y / N If yes, what type? _____ Start year: _____ Quit year: _____
Alcohol Consumption per day/week _____

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

- ☐ AIDS/HIV
- ☐ Alzheimer Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes: Type I/Type II
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B or C
- ☐ Herpes: I or II
- ☐ High Blood Pressure
- ☐ Hormone Therapy
  - ☐ Reason: _____
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Recurrent Infections
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep issues
  - Appliances used: _____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tattoos
- ☐ TMJ pain/dysfunction
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers/Acid reflux
- ☐ Venereal Disease

☐ Other condition(s) not listed above: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____
Date of last physical: _____
Are you under the care of any specialist physicians? ☐ 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

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 Phone

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

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
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

Cohen & Cohen Dental Group
818 18th Street NW, Suite 300 Washington, DC 20006
(202) 659-9100

Morris M. Cohen, DDS
Paul D. Cohen, DDS
Sara C. Cohen, DMD
Isabelle M. Lass, DDS
Brooke R. Miller, DDS

Dear New Patient,

This letter is a courtesy reminder of our 24-hour cancellation policy. We understand emergencies come up, yet without proper advance notice it is very difficult to utilize the time that has been reserved for you. The doctor's or hygienist's time you have reserved goes unused and we are unable to accommodate another patient who is waiting for an appointment. Reminder calls are provided prior to your appointment to ensure you are able to be here at your scheduled time. If something comes up, please provide us with 24 hours notice. We pride ourselves on keeping our fees reasonable and your cooperation helps us do this. In the future you may be charged up to the full fee of your appointment if proper notice is not received. We are dedicated to our patients and routinely work with patients to provide them with the appointment time that works with their schedule. We appreciate your understanding and look forward to caring for you for many years to come.

Sincerely,

Dr. Paul Cohen, DDS
Dr. Sara Cohen, DMD
Dr. Isabelle Lass, DDS
Dr. Brooke Miller, DDS
Dental Team of Cohen & Cohen

X_____
Signature of patient

NOTICE and ACKNOWLEDGEMENT

Acknowledgement:

I acknowledge I have been informed that the Notice of Privacy Practices from Cohen & Cohen Dental Group, P.A. is available to me to review in the patient waiting room. Additionally, a copy is available to me upon request in the office.

_____ _____

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient.