SHAWN COHEN DDS PLLC
COMPREHENSIVE DENTISTRY & IMPLANTOLOGY

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718.372.3151

WELCOME to our practice!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs

PATIENT INFORMATION

Today's Date ______________ Soc. Sec. # ______________________ DOB __________________________

Name ____ Email _____________________________
LAST FIRST used for email reminders, communications, etc

Address _______________________________ City ______________ State ________ Zip _______________

Home # _____________________ Business # _________________ Cell # ____________________________

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Widowed ☐Divorced

Employer _____________________ Phone _____________________ Occupation______________________

Business address _______________________ City ______________ State ________ Zip _______________

Who should we thank for referring you? ____

In case of emergency, who should we contact? ____________________ Phone _____________________

PRIMARY INSURANCE

(If no insurance, the person responsible for the account other than patient)

Person responsible for account or policy holder ____
LAST FIRST

Relationship to patient ________________ DOB ________________ Soc. Sec. # _____________________

Address __________________________________ City _____________ State ________ Zip ______________

Home # ______________________ Business# __________________ Cell # ____________________________

Dental Insurance Company ____

Policy ID # ______________________ Group ID # _________________ Employer ______________________

Medical Insurance Company ________________________ ID # ______________________________________
(IF APPLICABLE)

Notes:

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ASSIGNMENT AND RELEASE

I hereby authorize payments directly to Dr. Cohen for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize this office to release the information required to secure process of payments and benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Person: ________________________________ Date: __________

Continue on back ➔

Dental History

Former Dentist ______________________________
City, State ______________________________
Date of last dental visit ______________________________
Date of last X-ray radiographs ______________________________
How often do you floss? ______________________________
How often do you brush? ______________________________

Please check all that apply:

- Bad Breath..................... ☐
- Bleeding Gums.................. ☐
- Dry Mouth .... ☐
- Finger Nail Biting............... ☐
- Grinding Teeth.................. ☐
- Lip or Cheek Biting......... ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment......... ☐
- Pain Around Ear..................... ☐
- Periodontal Treatment............ ☐
- Sensitivity to Cold................. ☐
- Sensitivity to Heat................. ☐
- Sensitivity to Sweets........... ☐
- Sensitivity when Biting......... ☐
- Frequent Headaches............ ☐
- Jaw, Head Neck Injuries...... ☐
- Jaw Clicking and/or Pain...... ☐
- Tooth Pain.......................... ☐

Medical History

Primary Physician Name: ______________________________ Specialty: ____________________ Phone: ____________________
Last completed medical exam: ______________ Any past illness or operations? ______________________________

List ALL Medications taking:

Taking: ______________________________ For: ____________________ Dose: ________
Taking: ______________________________ For: ____________________ Dose: ________
Taking: ______________________________ For: ____________________ Dose: ________
Taking: ______________________________ For: ____________________ Dose: ________

	Yes	No
Are you currently under medical treatment?	☐	☐
Do you smoke?	☐	☐
Do you use alcohol, or drugs?	☐	☐
Specify:		
(Women Only) Are you:		
Pregnant?..	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Have you had any Allergic Reactions to the following:

	Yes	No
Local Anesthetic (eg. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
Other	☐	☐

Please check all that apply:

- AIDS / HIV+ .... ☐
- Anemia .... ☐
- Arthritis, Rheumatism .... ☐
- Asthma .... ☐
- Blood Disease .... ☐
- Cancer / Tumor................... ☐
- Chemotherapy .... ☐
- Cough – persistent or bloody ☐
- Diabetes .... ☐
- Drug Dependency .... ☐
- Emphysema .... ☐
- Epilepsy / Seizures .... ☐
- Excessive Bleeding .... ☐
- Fainting or Dizziness .... ☐
- Heart Murmur .... ☐
- Mitral Valve Prolapse .... ☐
- Hepatitis: type? .... ☐
- Herpes .... ☐
- High Blood Pressure .... ☐
- Liver Disease .... ☐
- Headaches .... ☐
- Pace Maker .... ☐
- Nervous Problems .... ☐
- Kidney Disease .... ☐
- Psychiatric Care .... ☐
- Heart Disease .... ☐
- Respiratory Disease ..... ☐
- Shortness of Breath ..... ☐
- Sinus Trouble .... ☐
- Artificial Heart Valve.... ☐
- Artificial Joints .... ☐
- Stroke .... ☐
- Thyroid Problems .... ☐
- Tuberculosis .... ☐
- Ulcers .... ☐
- Venereal Disease .... ☐
- Acid Reflux / Heart Burn ..... ☐
- Infectious Disease .... ☐
- Genetic Disorders .... ☐
- Serious Accident / Trauma... ☐
- Anxiety Disorders .... ☐
- Back / Neck Pain .... ☐
- Sleep Apnea .... ☐
- Swelling Feet/Ankles .... ☐
- Swollen Neck Glands .... ☐
- Glaucoma .... ☐
- Other Medical Problems...... ☐
- Drug Allergies .... ☐

Are there any other medical concerns or situations that you would like to discuss? ______________________________

NOTES: ______________________________

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The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the doctor and/or office staff of any and all updates to the information listed above.

Patient Signature: ______________________________ Date: ______________________________