

BARRY D. COHEN, D.D.S.



Orthodontics for Adults & Children
Oro-facial Orthopedics
TM Dysfunction

Member American Association of **Orthodontists**

TO OUR NEW PATIENTS:

Your kindness in furnishing the following information will be appreciated in preparing your clinical chart.

Please Print

Patient's Name _____ Date of Birth _____ Age: _____

Would like to be addressed as _____ Sex: Male _____ Female _____

Address _____ Home Phone () _____

_____ Pager # () _____

City _____ State _____ ZIP _____

Names/ages of other family members previously treated in our office: _____

Social Security # _____ Orthodontic Insurance Coverage? Yes _____ No _____

Method of Payment: Cash or check _____ Visa/MasterCard/Discover _____

Employer _____ Occupation _____

Employer address _____ Business phone () _____

_____ Cell phone () _____

City _____ State _____ ZIP _____

E-mail address _____

Spouse's name _____ Occupation _____

Social Security # _____ Date of Birth _____

Employer _____ Business phone () _____

Employer address _____ Cell phone () _____

_____ E-mail address _____

City _____ State _____ ZIP _____

Name of Dentist _____ Referred by _____

Responsible party (if different from above) _____

Social Security number of responsible party _____

Address of responsible party _____

Nearest relative not living with you and address _____

MEDICAL HISTORY

1. Who is your physician? _____ Date of last physical exam? _____
 Physician's Address _____ Physician's Phone No. () _____
2. Has there been any change(s) in your health within the past year? _____
3. Are you being treated by a physician for any reason at present? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident or surgery? _____
 If yes, when and why? _____
6. So that we may take the proper precautionary measures, are you pregnant or is there a possibility that you might be pregnant? YES NO

Have you ever had or presently have any of the following:	YES NO (CHECK ✓)	
	YES	NO
7. Heart Trouble (including heart murmurs, valve prosthesis/pacemaker)		
8. Rheumatic fever		
9. High/low blood pressure		
10. Kidney problems		
11. Liver disease (hepatitis)		
12. Jaundice		
13. Diabetes		
14. Anemia, Sickle Cell, Iron Deficiency, Etc.		
15. Prolonged bleeding		
16. Severe Infections		
17. Epilepsy		
18. Fainting		
19. Convulsions		
20. Pneumonia		
21. Tuberculosis		
22. Venereal Disease		

	YES	NO
23. Arthritis		
24. Allergy, hay fever, hives		
25. Asthma		
26. Sinus Problems		

Are you allergic to or have you had any unusual reactions to:	YES NO UNKNOWN		
	YES	NO	UNKNOWN
27. Penicillin			
28. Dental local anesthetics			
29. Barbiturates			
30. Codeine or other narcotics			
31. Aspirin			
32. Sedatives			
33. Sulfa			
34. Any other drugs medicines (Specify)			
35. Do you have any other disease, condition or emotional problems you would like to bring to our attention?			

