COHEN ORTHODONTICS

American Association of Orthodontists

Member American Association of **Orthodontists**

Orthodontics for Adults & Children
Oro-facial Orthopedics
TM Dysfunction

TO OUR NEW ADULT PATIENTS:
Your kindness in furnishing the following information will be appreciated in preparing your clinical chart.

Please Print

Patient's Name _____ Goes By _____ Age: _____

Sex: Male _____ Female _____ D.O.B. _____

Address _____ Home Phone ( ) _____

_____ E-mail Address: _____

City State ZIP

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

_____

Orthodontic Insurance Coverage? Yes _____ No _____ Carrier Name _____

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 _____

Employer _____ Date of Birth _____

Employer address _____ Business phone ( ) _____

_____ Cell phone ( ) _____

City State ZIP

E-mail address _____

Name of Dentist _____ Referred by _____

Responsible party (if different from above) _____

Address of responsible party _____

_____

Nearest relative not living with you and address _____

_____

_____

A B C

ADULT 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 ❑ N/A

Have you ever had or presently have any of the following:	YES (CHECK ✓)	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		
23. AIDS or HIV positive		
24. Arthritis		

	YES	NO
25. Osteoperosis		
26. Allergy, hay fever, hives		
27. Asthma		
28. Sinus Problems		

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

ADULT DENTAL HISTORY

What is your reason for coming to our office? _____

_____

_____

Have you ever been treated orthodontically before? ❑ YES ❑ NO

By whom? _____ Date of last visit _____

1. Date of last dental visit _____

2. Treatment at last visit _____

		YES (CHECK ✓)	NO
3. Have you ever experienced any dental pain?			
4. Have you ever had an unfavorable reaction to:	a. medical visit		
	b. dental visit?		
5. Any injuries to teeth, mouth or head?			
6. Do you have bleeding gums?			
7. Do you have frequent mouth ulcers or cold sores?			

8. What is your attitude toward dentistry and/or orthodontics? _____

_____

Additional comments _____

_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)

I give my consent for the initial examination at no charge.

Signature _____ Date _____