PATIENT REGISTRATION

PATIENT NAME_____ DATE OF BIRTH_____ OCCUPATION_____

ADDRESS_____ SOCIAL SECURITY #_____ - _____-_____ EMPLOYER_____

CITY _____ST_____ ZIP _____ DRIVERS LICENSE #_____ ADDRESS_____

HOME PHONE ( )_____-_____ MARRIED___ SINGLE ___ DIVORCED___ WIDOWED___ CITY _____ST_____ ZIP _____

WORK PHONE ( ) _____-_____ FULL TIME STUDENT____ PARTIME STUDENT_____ INSURANCE PLAN_____

CELL PHONE ( ) _____ - _____ SCHOOL_____ POLICY/GROUP#_____

E-MAIL _____ INDIVIDUAL I.D. # _____

INSURANCE SUBSCRIBER (if different from above) or LEGAL GARDIAN IF PATIENT IS A MINOR

NAME_____ DATE OF BIRTH_____ OCCUPATION_____

ADDRESS_____ SOCIAL SECURITY #_____ - _____-_____ EMPLOYER_____

CITY _____ST_____ ZIP _____ DRIVERS LICENSE #_____ ADDRESS_____

HOME PHONE ( )_____-_____ MARRIED___ SINGLE ___ DIVORCED___ WIDOWED___ CITY _____ST_____ ZIP _____

WORK PHONE ( ) _____-_____ INSURANCE PLAN_____

CELL PHONE ( ) _____ - _____ POLICY/GROUP#_____

E-MAIL _____ INDIVIDUAL I.D. # _____

FAMILY MEMBER NOT LIVING WITH PATIENT

RELATIONSHIP_____

NAME_____

ADDRESS_____

CITY _____ST_____ ZIP _____

PHONE ( )_____-_____

WHO MAY WE THANK FOR REFERRING YOU?

_____

_____

PERSON TO CALL IN CASE OF AN EMERGENCY

RELATIONSHIP_____

NAME_____

ADDRESS_____

CITY _____ST_____ ZIP _____

PHONE ( )_____-_____

APPOINTMENTS

Once an appointment is made please remember this time has been reserved exclusively for you. A minimum charge will be made for a failed or cancelled appointment without prior notification of at least 24hrs to offset our overhead for the time we reserved for you.

CONSENT TO USE PHOTOGRAPHS

I, the undersigned, hereby agree that Dr. Cohen may use my photograph in printed material and on the Internet for educational purposes and to promote Dr. Cohen's dental practice. I understand that I will not receive any compensation for said use. This consent shall remain in effect until withdrawn by me, by sending written notice to This Office.

TREATMENT CONSENT

I, the undersigned, hereby authorize Doctor Cohen and his staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by This Office to make a thorough diagnosis of the Patient's dental needs. I also authorize This Office to perform any and all forms of treatment, medication and therapy, which may be indicated. I also understand that dental treatment and the use of anesthetic agents embodies a certain risk, which may affect the health and well being of the Patient.

FINANCIAL RESPONSIBILITY

I understand the responsibility of payment for Dental Services provided by This Office for My Dependents or Myself is Mine, due and payable at the time services are rendered, regardless of any insurance coverage, unless financial arrangements have been made. I further understand that finance and/ or billing charge will be added to any overdue balances (minimum $5.00 per month or 1.5% per month (18%apr) which ever is greater). I hereby assign all insurance benefit payments to This Office.

I have read my plan benefits, exclusions and limitations and I take full responsibility for understanding such regardless of any other representations which may have been made by This Office.

PATIENT'S/LEGAL GARDIAN'S SIGNATURE _____ **DATE**_____

PATIENT MEDICAL HISTORY

Patient Name: _____ Are you currently in good health? _____

Medical Doctor's Name: _____ Phone ( ) _____ Last physical exam date_____

Do you have or have you ever had the following?

Y	N	
		Allergies to drugs
		Allergies to Anesthetics
		Heart Ailments
		Rheumatic Fever
		Mitral Valve Prolapse
		Congenital Heart Defects
		Heart Surgery
		Heart Attack
		Prosthesis (heart valve, stent, etc.)
		High Blood Pressure
		Neurological Problems
		Epilepsy or Seizures
		Nervous Disorders
		Psychiatric Care/Emotional
		Radiation Therapy
		Malignancies
		Ever taken Bisphosphonates
		Osteoporosis Medications

Y	N	
		Excessive Bleeding from Cuts
		Hemophilia
		Blood Transfusion Dates_____
		Arthritis
		Asthma
		Tuberculosis
		Respiratory Disease
		Artificial Implant (knee, hip, etc.)
		Thyroid
		Sinus Problems
		Liver Problems
		Hepatitis
		Diabetes
		Ulcer or Colitis
		Hayfever or Allergies
		Glaucoma
		Eye disorders
		Ever taken Fen Phen

Y	N	
		Tonsillitis
		Herpes (oral or genital)
		HIV or AIDS
		Eating Disorders
		Alcohol or Chemical Dependency

Have you ever been hospitalized or had any Surgeries? Y __ N __

List dates_____

_____

FEMALES ONLY

Are you Pregnant? Y __ N __
What Month? _____

Are you presently under the care of a physician? (If so, what for)_____

Are you taking any medications currently? (If so, which)_____

DENTAL HISTORY

Reason for this visit? _____ Is this an emergency? _____When did it start? _____
Is there anything that relieves the pain? _____ Makes it worse? _____
Date of last dental exam? _____ Date of last dental x-rays? _____
Have you ever had a bad experience at the Dentist? (If so, describe)_____
Have you ever had any major dental treatment? (If so, describe)_____
How often do you normally visit the Dentist? __ 3 months __ 6 months __ Yearly __ Emergencies only
Name and location of previous dentist? _____Why did you leave? _____
May we request x-rays? _____

Y	N	
		Injury to Face or Jaws
		Bleeding Gums
		Burning sensation of the tongue
		Periodontal surgery or treatment
		Orthodontics
		Tobacco use (smoking/chewing)

Y	N	
		Frequent cold sores or blisters
		Teeth Sensitive to hot or cold
		Teeth Sensitive to biting
		Teeth Sensitive to sweets
		Swelling or Lumps in the mouth
		Unpleasant taste

Y	N	
		Complications from extractions
		Frequent headaches
		Tenderness in Jaw Joint
		Clenching or Grinding
		Noise in ears or Jaw Joint
		Bad Breath

How often do you Brush ___How often do you Floss? ____Other Oral Hygiene Aids? _____
Describe any unusual Dental Events or Experiences you have had_____

Patient/Legal Guardian Signature_____ Date _____

Reviewed _____ Date _____

DANIEL JEFFREY COHEN, D.D.S., Inc.

GENERAL, COSMETIC & FAMILY DENTISTRY
27871 MEDICAL CENTER ROAD, SUITE 100
MISSION VIEJO, CA 92691
(949) 364-1140

The following is a list of payment options from which you can choose. Please check the option that best suits your needs. We will submit your insurance for any option you choose.

❑ **Option 1—Patient's <u>without</u> insurance**

I wish to pay in full by (check one) _____Cash _____ Check _____ Credit Card* at the time of service. *Please fill in cardholder information below.

❑ **Option 2 – Patient's <u>with</u> insurance**

I wish to wait to be billed until my insurance claim is paid. I authorize payment of my balance with my credit card. All balances over 60 days old will be billed to my Credit Card regardless of insurance. *Please fill in cardholder information below.

❑ **Option 3 – Patient's with extensive treatment.**

I wish to make arrangements to have my balance financed over an extended period of time using "Care Credit" financing. (Our office will guide you through the application process)

Patient Name _____

Patient Signature _____ **Date** _____

Cardholder Information

I authorize Daniel Jeffrey Cohen, D.D.S., to keep my signature on file and to charge my (check one) ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express. I understand that this form is valid indefinitely unless I cancel the authorization through written notice to Dr. Cohen.

Cardholder Name _____

Cardholder Address _____

City _____ State _____ Zip _____

Account # _____Verification Code_____ Exp Date _____

Signature _____ Date _____