



First Name _____ MI _____ Last Name _____

DOB _____ Sex (please circle) M or F SSN _____ (Required for insurance verification)

Address _____ City _____ State _____ Zip _____

Email Address: _____ Primary Phone: (____) _____

Employer _____ Marital Status: (Please Circle) Married Single Divorced Widowed

If married, please include spouse information below:

Last Name _____ First Name _____ MI _____

DOB _____ Primary Phone (____) _____

Primary Insurance Co _____ **Secondary Ins Co** _____ **Insurance cards must be provided***

Subscriber Name _____ **Subscriber DOB** _____ **Subscriber SSN** _____

Member ID _____ **Group #** _____ **Employer** _____

Is this patient their own legal guardian? (please circle) YES or NO

Legal Guardian Name: _____ Legal Guardian Phone: (____) _____ - _____

Legal Guardian Email: _____ ***Please provide legal guardianship paperwork***

If patient is a minor: Name of Parent _____ Parent's DOB _____

Emergency Contact Name _____ **Emergency Contact Phone Number** _____

Where did you hear about us? (Please Circle)

Google/Yelp Practice Website Facebook Family/Friend/Coworker Internet Other

Dental History (On a scale of 1-5, with 5 being the highest rating)

How important is your dental health to you? 1 2 3 4 5

Where would you rate your current dental health? 1 2 3 4 5

What would you like to change about your smile? (Circle any that apply)

Color Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

Would you like to learn more about your **Invisalign** options? _____

Dental History Continued (Please circle any and all of the following conditions that apply to you)

Appearance

Discolored teeth
Worn teeth
Misshaped teeth
Crooked teeth
Spaces
Overbite
Flat teeth

Function

Grinding/Clenching
Headaches
Jaw Joint (TMJ) pain/popping
Bad Bite
Speech Impediment
Mouth Breathing
Difficulty Opening/Closing
Difficulty Chewing

Habits

Thumb Sucking
Nail-biting
Cheek/Lip Biting
Chewing on ice/foreign objects

PREVIOUS COMFORT OPTIONS

Nitrous Oxide
Oral Sedation (Pill)
IV Sedation

Pain/Discomfort

Sensitivity (hot, cold, sweet)
Pressure
Broken teeth/fillings
Worn Teeth
Dry Mouth

Periodontal (Gum) Health

Bleeding/Swollen Gums
Bad Breath
Loose tipped, shifting teeth
Previous perio/gum disease

Sleep Pattern or Conditions

Sleep Apnea
Snoring
Daytime Drowsiness

Social

Tobacco use
Alcohol Frequency _____
Drug Frequency _____

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS

Cancer

Type _____
Chemotherapy
Radiation Therapy

Endocrinology

Diabetes
Hepatitis (A/B/C)
Jaundice
Kidney Disease
Liver Disease
Thyroid Disease

Musculoskeletal

Arthritis
Artificial Joints
Rheumatoid Arthritis

Viral Infections

AIDS
HIV Positive
HPV

Cardiovascular

Angina (chest pain)
Artificial Heart Valve
Heart Conditions
Heart Surgery
High/Low Blood Pressure
Mitral Valve Prolapsed
Stroke
Pacemaker
Rheumatic Fever
Scarlet Fever

Respiratory

Emphysema
Asthma
Sinus Issues
Tuberculosis

Mental

Autism Spectrum
Anxiety
Depression
Dizziness
Drug/Alcohol Addiction
ADD/ADHD
Intellectual Disabilities
Seizures
Psychiatric Illness

MEDICAL ALLERGIES (circle any and all that apply)

Antibiotics (Penicillin/Amoxicillin/Clindamycin)
Opioids (Percocet, Oxycodone, Codeine)
Latex
Local Anesthetics
Other _____

Please list any other health issues or conditions:

Height: _____

Weight: _____

Preferred Pharmacy: _____

Phone Number: (____) _____ - _____

Do you require a **Pre-Medication** prior to dental appointments?

If so, which medication? _____

Are you currently pregnant or breastfeeding? _____

Have you had any serious illness, operation, or hospitalization in the past 5 years?

Consent: The undersigned hereby authorizes Seth J. Cohen DDS LLC to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions. I certify that I have read and understand the questions asked in this Patient Registration and Medical History section on this form. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Sign Here: _____
Signature of Patient/Legal Guardian

Today's Date: _____

NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request a copy of the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Crown Town Dental reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name (Printed)

Today's Date

Signature of Patient / Legal Guardian

Relationship to Patient (if other than Self)

PAYMENT FOR SERVICES

We expect full payment at the time of service, unless another financial agreement is made in advance. For your convenience, we accept Mastercard, American Express, Visa, Discover, check, cash, and Care Credit.

REGARDING INSURANCE

Crown Town Dental will gladly file your insurance, as a courtesy to you, but your estimated portion, including co-pays and deductibles, is due at the time services are rendered. Your insurance is a contract between the insurance company, your employer and you. We are, typically, not a party in this contract. Please be aware that some, and perhaps all, of the services we provide to you may be non-covered services and not considered "reasonable and necessary" under your dental insurance. If for any reason your insurance carrier does not pay the full estimated benefit, the remaining portion will become the responsibility of the patient or responsible party. We will do everything, within reason, to collect from your dental insurance you have provided, within 60 days from your treatment date. If after 60 days, your insurance company has not paid for the services provided, any remaining portion for the corresponding services, will become the responsibility of the patient or responsible party. You can then, contact your dental insurance, directly, for any reimbursements. We will provide you with any necessary documents, upon your request.

CANCELLATION POLICY

When we make your appointment, we are reserving a room for your particular needs. If you must change an appointment, we ask that you give us at least two business days. This courtesy makes it possible to give your reserved room to another patient who needs it. **Patients who don't confirm at least 24 hours in advance risk being canceled.** Repeated cancellations or missed appointments will result in loss of future appointment privileges and/or dismissal from the practice. Sedation appointments are sometimes scheduled months in advance. For this reason, **patients who no show or cancel a sedation appointment without giving a notice of at least 7 business days from the scheduled procedure, will be charged a fee of \$100, which is non-refundable and non-negotiable.**

LATE PAYMENT PENALTY

Any account 90 days past due may be turned over to collections and will be charged 25% of the balance due for collection fees.

CONSENT TO RELEASE OF PATIENT INFORMATION AND RECORDS

I hereby give my permission for the release of my records, including but not limited to radiographs, photographs and impressions, for the purpose of professional consultation, referrals to another dental or specialist's office and/or fabrication of dental prosthesis or appliances by dental laboratories. Transmission of these records may be completed via mail, fax and/or unencrypted email. No information obtained from the medical history form will be transmitted via unencrypted email; however, patient name, age, birthdate and gender may be used to identify radiographs and photographs.

Patient Name (Printed)

Today's Date

Signature of Patient / Legal Guardian

Relationship to Patient (if other than Self)

Patient Release of Information Authorization Form

Under the requirements of HIPPA, we are not allowed to discuss a patient's financial or medical information with anyone without written consent. If you wish to have your medical information, exam findings, treatment plans, or financial information shared or discussed with a family member, guardian, or anyone else on your behalf, this form must be completed.

I authorize *Seth J Cohen DDS* to release my medical and/or financial records and/or discuss any and all exam findings with the following individuals:

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Patient Name (Printed)

Today's Date

Signature of Patient / Legal Guardian

Relationship to Patient (if other than Self)