

Jeffrey M. Cohen, D.M.D.
4324 Forest Hill Boulevard, West Palm Beach, FL 33406
www.TheCosmeticDentist.com
561-967-8200

CONFIDENTIAL HEALTH HISTORY

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

Primary Physician: _____ Telephone Number: _____

Additional Physician: _____ Telephone Number: _____

Date of Last Medical Exam: _____ Height _____ Weight _____

List Current Medications	
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Past Medical Problems: (Please check all that apply)

- | | | |
|--------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Gastritis/GERD/Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Para/Thyroid Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prosthetic Replacement |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Lesion | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Asthma/Hay Fever/Cough | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Blood Disease/Disorder | <input type="checkbox"/> Hepatitis (circle A B C) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV +/-AIDS | <input type="checkbox"/> Serious Accident |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Pain/Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke/TIAs |
| <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Supervised Diet |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Tobacco Dependency |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Major Surgery | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Prolapse | <input type="checkbox"/> Other _____ |

Are you pregnant? YES NO

Are you required to **PRE-MEDICATE** for dental procedures? YES NO

PLEASE READ AND SIGN

I have read the statements and answers to the above questions. I affirm that they are complete and true to the best of my knowledge and belief.

Patient/Guardian Signature: _____ Date: _____

Dental Health Care Florida, Inc.
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Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to pay all Dental Health Care Florida, Inc. charges to Dental Health Care Florida, Inc. in accordance with the regular rates and terms of Dental Health Care Florida, Inc. and agree to pay for any charges not covered by any third party payer. Dental Health Care Florida, Inc. files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied directly to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that Dental Health Care Florida, Inc. is relying upon the undersigned(s) to pay in treating the patient.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____

If patient is under age 18, I hereby give my permission for _____ to be treated by Dental Health Care Florida, Inc.

Consent to Dental and Surgical Treatment: The undersigned hereby consents to all dental care and services, surgical treatment, examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a Dentist, their Hygienists, Dental Assistants, employees, associates or designees may deem advisable to the undersigned patient during this treatment.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____

HIPAA/Notice of Privacy Practice: I have been provided information by Dental Health Care Florida, Inc. regarding their privacy practices.

Patient Signature: _____ Date: _____

Responsible Party: _____ Relationship to Patient: _____ Date: _____

Assignment of Insurance Benefits: I hereby authorize payment directly to Dental Health Care Florida, Inc. and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance and further direct any such insurance company to make payment of benefits directly to Dental Health Care Florida, Inc. I understand that I am financially responsible to Dental Health Care Florida, Inc. for charges not covered by this assignment.

Lifetime Signature Authorization: I hereby authorize Dental Health Care Florida, Inc. to furnish to my insurance company or their representative or to the billing agent of Dental Health Care Florida, Inc. any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

Responsible Party: _____ Relationship to Patient: _____ Date: _____