PATIENT DEMOGRAPHIC WORKSHEET

Patient Name: ______________________ Date of Birth: ____________ Age: ______ Sex: M F

SSN: ________________ E-Mail Address: ______________________ Marital Status: S M W D

Street Address: ______________________ City: ______________ State:_____ Zip Code: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ________________

Name of Employer: ______________________ Occupation: __________________________

Emergency Contact Person: __________________ Emergency Contact Phone: __________________

Preferred Pharmacy Name: __________________ Pharmacy Phone Number: __________________

How did you hear about our office? ____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: __________________ Policy Holder Name: ______________________

Policy Holder Date of Birth: ________ Policy Holder SSN: ____________ Relationship to Patient: ____________

Name of Employer: ______________ ID Number: ________________ Group Number: ______________

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)

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

Are you pregnant? o YES o NO

Are you required to **PRE-MEDICATE** for dental procedures? o YES o 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:** ________