Greg Cohen, DDS
6231 SW 29th Street
Topeka, KS 66614

Date: ___________________

Patient Information: Referred By:________________________________

____ Marital Status: M S W D Sex: Male Female
Last Name First MI

____________________________________ ____________________________________
Employer/If Student, Name of School Email Address

____________________ ____________________ ____________________
Social Security Number Driver's License Number Date of Birth

____
Street Address City State Zip

____________________ ____________________ ____________________
Home Phone Cell Phone Work Phone

Responsible Party Information:

____________________________________ ____________________________
Name of Responsible Party Relationship to Patient

____
Address (if different from patient)

____________________ ____________________ ____________________
Social Security Number Driver's License Number Date of Birth

In case of emergency, name of nearest relative and phone number: ________________________________

Insurance Agreement

Primary Dental Insurance

Insurance Company: ____

Insurance Address: ____

Policy Holder's Name: ________________________ SS#: ______________ DOB: ______________

Policy Holder's Employer: ________________________ Relationship to Patient: ______________

Policy ID#: ________________________Group Number/Name: ________________________

Secondary Dental Insurance

Insurance Company: ____

Insurance Address: ____

Policy Holder's Name: ________________________ SS#: ______________ DOB: ______________

Policy Holder's Employer: ________________________ Relationship to Patient: ______________

Policy ID#: ________________________Group Number/Name: ________________________

1. The undersigned hereby authorizes payment directly to Dr. Greg Cohen of any dental insurance benefits otherwise payable, but not to exceed said doctor's regular charges for such services. Refunds will be paid promptly.
2. The undersigned hereby consents to and authorizes Dr. Greg Cohen to disclose and make available to representatives for the insurance company, all records and information relating to the treatment or examination of the patient upon inquiry.
3. The undersigned understand that the insurance company may pay less than the actual bill for services and agrees to be responsible for payment of all services rendered to the patient.
4. We reserve the right to charge $30 for all broken appointments – unless a 24 hour notice is given.

____________________________________ ____________________
Patient/Responsible Party/ Guardian Date

Patient Health History

Greg Cohen, DDS

Name:____________________

Medical Conditions

- ☐ None
- ☐ Low Blood Pressure
- ☐ AIDS
- ☐ Diabetes
- ☐ Mitral Valve Prolapse
- ☐ Anemia
- ☐ Dementia
- ☐ Pace Maker
- ☐ Arthritis, Rheumatism
- ☐ Diet (Special/Restricted)
- ☐ Psychiatric Care
- ☐ Artificial Heart Valve(s)
- ☐ Dizziness/Fainting
- ☐ Radiation Treatment
- ☐ Artificial Joints
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Back Problems
- ☐ Excessive Bleeding/Bruising
- ☐ Scarlet Fever
- ☐ Blood Disease
- ☐ Glaucoma
- ☐ Sinus Problems
- ☐ Blood Thinner
- ☐ Hay Fever
- ☐ Skin Rash
- ☐ Blood Transfusion
- ☐ Head Injuries
- ☐ Stomach Problems/ Ulcer
- ☐ Cancer
- ☐ Heart Murmurs
- ☐ Stroke
- ☐ Chemical Dependency
- ☐ Heart Problems
- ☐ Swollen Feet or Ankles
- ☐ Chemotherapy
- ☐ Hepatitis
- ☐ Swollen Neck Glands
- ☐ Circulatory Problems
- ☐ Herpes
- ☐ Thyroid Problems
- ☐ Cold Sores/Fever Blisters
- ☐ High Blood Pressure
- ☐ Tobacco Use
- ☐ Congenital Heart Lesions
- ☐ Jaundice
- ☐ Tonsillitis
- ☐ Contact Lenses
- ☐ Jaw Popping/Pain
- ☐ Tuberculosis
- ☐ Cortisone Treatments
- ☐ Kidney Disease
- ☐ Tumors
- ☐ Cough, persistent or bloody
- ☐ Liver Disease
- ☐ Venereal Disease
- ☐ X-Rays/Cobalt Disease

Other:

Allergies

☐ None

Are you allergic to or have you had any adverse reactions to the following:

Antibiotics	*Other Drugs*	*Other Allergies*
☐ Amoxicillin	☐ Acetaminophen	☐ Latex
☐ Cephalexin	☐ Aspirin	☐ Metals (nickel, mercury, etc.)
☐ Erythromyc	☐ Barbiturates	☐ Nuts
☐ Keflex	☐ Codeine	
☐ Penicillin	☐ Hydrocodone	
	☐ Ibuprofen	
	☐ Iodine	
	☐ Local Anesthetics	
	☐ Sulfa	

Other:

Current Medications

☐ None

__________________ __________________

__________________ __________________

__________________ __________________

__________________ __________________

Addt'l Info:

Are you currently under medical treatment of any kind? ☐ No ☐ Yes

Are you now or have you ever used a bisphosphonate to treat Osteoporosis? (Actonel, Atelvia, Boniva, Fosamax) ☐ No ☐ Yes

Have you been admitted to a hospital or needed emergency care within the last 2 years? ☐ No ☐ Yes

Do you have any health issues or conditions that need further clarification? ☐ No ☐ Yes

☐ Pregnant Due Date:

☐ Nursing

☐ Taking oral contraception

Signature

Date