STEVEN D. COHEN, D.M.D., PC
SUDBURY DENTAL CENTER
57 CODJER LANE
SUDBURY, MA 01776
(978) 443-3992 (888) RING-DMD
www.SudburyMaDentist.com

ADULT PATIENT INFORMATION MEDICAL AND DENTAL HISTORY

NAME ☐ SINGLE ☐ MARRIED ☐ M/F ☐ DATE OF BIRTH

PREFERRED APPT. TIMES MORNING AFTERNOON EVENING ANYTIME M T W TH F S

BEST TIME TO CALL YOUR HOME PHONE YOUR EMAIL ADDRESS

RESIDENCE ADDRESS CITY STATE ZIP

EMPLOYED BY CITY STATE YOUR BUSINESS PHONE

PERSON TO NOTIFY IN CASE OF EMERGENCY: NAME ADDRESS PHONE #

THE FOLLOWING QUESTIONS AND ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL:

PATIENT MEDICAL HISTORY

Your Physician's Name _____ Physician's Office Phone_____

Address _____Approximate date of your last physical examination _____

Your medical health, please check one ☐ Excellent ☐ Good ☐ Fair ☐ Poor

	Yes	No
1. Are you under any medical treatment now?	☐	☐
2. Have you had any major operations? If so, what?	☐	☐
3. Have you had any adverse response to any drugs including penicillin, aspirin, codeine, barbiturates or novocaine?	☐	☐
4. Are you allergic to any metals especially nickel, berylium, chrome, silver, gold, or mercury? (Circle which ones)	☐	☐

5. Has a physician ever informed you that you had or do you have:

Please CHECK if you have or have had any of the following:

☐ Heart Trouble	☐ Chest Pain	☐ Sinus Trouble	☐ X-Ray or Cobalt Treatment
☐ High Blood Pressure	☐ Shortness of Breath	☐ Emphysema	☐ Chemotherapy/Radiation
☐ Low Blood Pressure	☐ Swelling of Feet/Ankles/Hands	☐ Frequent Cough	☐ Arthritis/Gout
☐ Heart Murmur	☐ Fainting or Dizziness	☐ Lung Disease	☐ Glaucoma
☐ Rheumatic Fever	☐ Stroke	☐ Liver Disease	☐ Epilepsy or Seizures
☐ Congenital Heart Lesion	☐ Diabetes	☐ Hepatitis A (infectious)	☐ Alzheimer's Disease
☐ Artificial Heart Valve	☐ Artificial Joints/Hips	☐ Hepatitis B (serum)	☐ Hypoglycemia
☐ Heart Pacemaker	☐ Kidney Trouble	☐ Hepatitis C	☐ Psychiatric Care
☐ Heart Surgery	☐ Ulcers	☐ Recent Weight Loss	☐ Hemophilia
☐ Mitral Valve Prolapse	☐ Allergies	☐ Cancer	☐ HIV Positive
☐ Blood Disease	☐ Asthma	☐ Thyroid Disease	☐ Latex Allergy
☐ Anemia	☐ Hay Fever	☐ Parathyroid Disease	

6.	Have you had recent unexplained weight loss?	☐	☐
7.	Are you allergic to any know materials resulting in hives, asthma, eczema, etc.?	☐	☐
8.	Are you in general good health at this time?	☐	☐
9.	Have any wounds or cuts healed slowly or bleed a long time or presented other complications?	☐	☐
10.	Do you have normal color vision?	☐	☐
11.	**WOMEN:** Are you pregnant now?	☐	☐
	Are you taking birth control pills?	☐	☐
	Are you aware that taking antibiotics can render birth control pills ineffective?	☐	☐

Have you ever had any other serious illness not checked above? Yes ☐ No ☐ If yes, please describe in detail:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____

Date Signature of Patient, Parent or Guardian

Reviewed By: _____

Dr. Steven D. Cohen Date

ANNUAL UPDATE

CURRENT MEDICATION	REASON	UPDATE	PATIENT SIGNATURE	PROVIDER INITIAL

DENTAL INFORMATION

Do You Presently Have a Dental Complaint?_____

	Yes	No
12. Do you ever have a bad taste in your mouth?	☐	☐
13. Do you smoke? How much? _____ How often? _____ Cigars ☐ Pipe ☐ Cigarettes ☐ Snuff ☐	☐	☐
14 Do you drink alcohol? How much? _____ How often? _____	☐	☐
15. Do you have difficulty opening your mouth?	☐	☐
16. Does your jaw get "stuck", "locked", or make noises or "go out"? If so, circle one	☐	☐
17. Do you have pain in or about the ears or cheeks?	☐	☐
18. Do you have pain when chewing/clenching/yawning or opening wide?	☐	☐
19. Does your bite feel uncomfortable or unusual?	☐	☐
20. Have you ever had an injury to your jaw, head or neck?	☐	☐
21. Do you have headaches frequently?	☐	☐
22. Do you habitually clench your teeth during the night or day?	☐	☐
23. Do you ever wake up with tired jaw muscles?	☐	☐
24. Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)	☐	☐
If so, where?_____		
25. Are your teeth sensitive to: cold foods or drinks, hot foods or drinks, acidic foods	☐	☐
or to breathing outside on cold days?	☐	☐
26. Have you experienced any growths or sore spots in your mouth?	☐	☐
27. Does food catch between your teeth?	☐	☐
28. How often do you brush your teeth? _____	☐	☐
What type of brush? ☐ Manual ☐ Soft ☐ Medium ☐ Hard ☐ Electric ☐ Brand _____		
29. How often do you floss your teeth? _____ Waxed ☐ Unwaxed ☐		
30. Do you ever have an unpleasant odor or taste after flossing?	☐	☐
31. If you floss, does it shred or break between your teeth?	☐	☐
32. Do you use any other devices to clean your teeth or gums? - Please describe - _____		
33. Are you apprehensive the night before or the day of your dental appointment?	☐	☐

34. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

OFFICE INFORMATION

CANCELLATIONS: We require at least a 24 hour business day (M-F) per 1/2 hour of appointment time advance notice to cancel or reschedule an appointment. This fee covers only a portion of the overhead such as rent, salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you, and only you. Without this notice a charge will be made for failed, broken, cancelled or rescheduled appointments..

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. **We do accept payment from your insurance carrier.**

CHILDREN'S DENTAL FEES: Children's dental fees are posted to the responsible parent's account which is defined as the parent who brings the child to the office. Other arrangement can possibly be formally made to fit specific situations.

COPIES OF RECORDS & X-RAYS: It is our policy that only copies of original x-rays and records be forwarded at your written request in the event that you move. There may be a fee for this procedure.

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All new patient emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, or a rebilling fee will be posted to that account.

I understand that any fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination and quote.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party