CONFIDENTIAL REGISTRATION AND MEDICAL HISTORY FORM

For the dental office of:

Jamie Cohn, DDS 31 Sherman Ave. Glens Falls, NY 12801 Phone: (518) 792-3281

DATE___________________

NAME:____
Last First Middle

PHONE#'S HOME:_______________________ H
WORK:_______________________ W
CELL:_______________________ C
Circle Preferred

ADDRESS: ____

CITY: _____________________________________ STATE:_______ ZIP CODE:______________

DOB:_____________ SEX: M F SINGLE____ MARRIED____ NAME OF SPOUSE__________________

SOCIAL SECURITY # :_______-_________-__________ E-Mail:_____________________________________

DENTAL INSURANCE PLAN/ CO.:______________________ OCCUPATION / EMPLOYER:______________________

REFERRED BY:____

COVID19 SCREENING

In the past 2 weeks:

Have you tested positive for Covid 19? Yes _____________ No __________________

Have you had any symptoms of Covid 19? Yes ______________ No ______________

Have you knowingly had contact with anyone who has tested positive or had symptoms? Yes ________ No ___________

Have you traveled outside New York State in the last 2 weeks? Yes ___________ No ______________

DENTAL HISTORY

LAST DENTAL VISIT :___________________________

YOUR DENTAL GOAL: ____
CHIEF DENTAL COMPLAINT: ____

Have you had any serious trouble associated with any previous dental treatment? ____**YES** ____**NO**

If so, explain____

MEDICAL HISTORY

Your Primary Care Physician / Medical Group Address: ____
Phone Number: ____

MEDICAL ALERTS:____

Date of Last Physical Exam: ____________________

Are you now or have you recently been under specialist physician's care? **YES** _____ **NO** _____
Reason: ____

Have you ever been hospitalized for or had any serious illness?
Explain: ____

Has any physician or previous dentist recommended taking antibiotic prior to dental treatment? YES _____ NO _____

If so, for what condition(s) ____

Check any of the following that you have had or suspected:

YES	NO		YES	NO		YES	NO	
______	______	Arthritis	______	______	Sleep Apnea	______	______	Cholesterol High/ Low
______	______	Acid Reflux/GERD	______	______	Stomach Problems	______	______	Persistent Diarrhea or Weight Loss
______	______	Rheumatic Fever	______	______	Hepatitis or Jaundice	______	______	Fainting Spells/ Seizure's
______	______	Damaged/Replaced Heart Valve	______	______	Tuberculosis	______	______	Glaucoma
______	______	High/Low Blood Pressure	______	______	Kidney/ Bladder Trouble	______	______	Heart Murmur
______	______	Diabetes Type I /Type II	______	______	Mental Disorders	______	______	Chest Pain
______	______	Anemia	______	______	HIV or AIDS	______	______	Stroke
______	______	Lung Disease	______	______	Shortness of Breath	______	______	Venereal Disease
______	______	Blood Transfusions	______	______	Blood Disease	______	______	Thyroid Disease
______	______	Asthma or Hay Fever	______	______	Cancer or Tumors	______	______	Sinus Trouble
______	______	Epilepsy/Other Neurological Disease	______	______	Radiation Treatment			

Do you smoke? _____Yes _____No _____Quit How long? ____________________

Do you use chewing tobacco? _____Yes _____No _____Quit How long? ____________________

Please list all current medications or supply a list:

____
____
____
____
____

Are you taking any over the counter meds, vitamins and / or supplements? ____**YES** ____**NO**
If so, please list:

____

<u>Are you allergic to or do you suffer ill effect from any of the following?</u> **YES** _____ **NO**_____

____Penicillin ____Codeine ____Dental Anesthesia
____Sulfa ____Latex ____Iodine
____Aspirin ____Household Bleach ____Other : _________________________

Women Only: Are you Pregnant? ____**YES** ____**NO**
If yes: How many months? ____ Are you breast-feeding? ____
Are you presently taking medicine of any kind? ____
(Birth control pills, shots or implant, hormone therapy, etc.) ____
Explain:____

The above information is true to the best of my knowledge.

PATIENT'S NAME OR RESPONSIBLE PARTY FOR PATIENT AND RELATIONSHIP

Signature:____ **Date:** _______________

<u>Financial responsibility statement:</u>

Payments for services rendered are the full responsibility of the patient or guarantor of account. Generally, all payments are due in full at the time of service unless prior arrangements are made. We accept cash, personal checks and all major credit and debit cards.
This office does not participate with any dental benefits program. Your dental benefits contract is between you and your benefits provider. Our office cannot accept responsibility for the terms of your contract. However, as a service and courtesy to our patients, we will do our best to assist in filing your dental claim so you can be reimbursed directly by your benefits plan. If financial arrangements must be made, they must be made and agreed upon in advance of any services to be provided. If you are billed by us for any portion of services not covered, the balance is due upon receipt.

"I understand and agree that I am responsible for all payments on my account. As guarantor, I understand and agree that I am responsible for any balances incurred by family or other members listed on the same account.

Print Patient Name: ________________________________ **Responsible Party/Guarantor:** ________________________________

Patient/Guarantor Signature: ____ **Date:** _______________________

Upstate Family Dental
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