Houston
Oral Surgery &
Dental Implant Center

General Patient Information

Patient Full Name: ______________________________

Date of Birth: ______________ Sex: ________ Social Security No.: ______________

Address: ______________________________ Apt #: ________

City: ______________________ State: ________ Zip: ______________

Phone Number: ______________ Cell Phone Number: ______________

Email: ______________________Referring Doctor: ______________

Emergency Contact: ______________________Phone: ______________

Full-Time Student: ☐ Yes ☐ No If yes, name of college: ______________

Responsible Party Info/Insurance Subscriber Info: *The family member your insurance is through

Full Name: ______________________________ Date of Birth: ________

Relationship to Patient: ______________ Social Security No.: ______________

Address: ______________________________ Apt #: ________

City: ______________________ State: ________ Zip: ______________

Phone Number: ______________ Cell Phone Number: ______________

Employer: ______________________________

Medical Insurance Carrier: ______________________________

Member ID#: ____________ Group ID#: ____________ Phone#: ______________

Dental Insurance Carrier: ______________________________

Member ID#: ____________ Group ID#: ____________ Phone#: ______________

Signature: ______________________ Date: ______________

OFFICE NOTES - Leave Blank- For Office Use Only

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Houston
Oral Surgery &
Dental Implant Center

Donald F. Cohen DDS
Oral & Maxillofacial
Surgeon

Medical History

Name: ____________________________

Height: ________ **Weight:** ________ **Age:** _______

ALLERGIES & MEDICATION

Please list all known allergies :

____

Please list all current medications :

____

***Please answer all questions correctly and completely. Your answers are for our records only and will be kept confidential.**

- Are you in good health? .... ☐ Yes ☐ No
- Has there been any change in your health in the past year? .... ☐ Yes ☐ No
- Date of last physical exam: ______________________
- Are you now under the care of a physician? .... ☐ Yes ☐ No
  If yes, for what condition?: ____
  Physician's full name : ____
- Have you had any serious illness, operation, or hospitalization? .... ☐ Yes ☐ No
  If yes, please explain: ____
- Are you taking or have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, or other antiresorptive drugs)?.. ☐ Yes ☐ No
- Are you pregnant? .... ☐ Yes ☐ No
- Are you nursing? .... ☐ Yes ☐ No
- Are you taking birth control? .... ☐ Yes ☐ No
- Do you wear contact lenses? .... ☐ Yes ☐ No
- Do you have any of the following diseases or problems?

  - ☐ Rheumatic Heart Disease
  - ☐ Low/High Blood Pressure
  - ☐ Shortness of Breath/Emphysema
  - ☐ Heart Attack
  - ☐ Heart Surgery/Valve Replacement
  - ☐ Chest Pain
  - ☐ Heart Murmur
  - ☐ Any Other Heart Trouble
  - ☐ Anemia or Other Blood Disorder
  - ☐ Abnormal Bleeding
  - ☐ Other Blood Disorder
  - ☐ Stroke
  - ☐ Frequent Mouth Sores
  - ☐ Neurologic Disorder or Epilepsy
  - ☐ Anxiety or Psychiatric Conditions
  - ☐ Fainting Spells or Seizures
  - ☐ Kidney Trouble
  - ☐ Osteoporosis
  - ☐ Prosthetic Joint(s)
  - ☐ Diabetes
  - ☐ Thyroid Problems
  - ☐ Hepatitis, Jaundice, or Liver Disease
  - ☐ Stomach Ulcers/Reflux
  - ☐ Immune Deficiency
  - ☐ AIDS/HIV Positive
  - ☐ Arthritis or Painful Joints (Including TMJ)
  - ☐ Asthma or Hay Fever
  - ☐ Respiratory Problems
  - ☐ Sinus Trouble
  - ☐ Persistent Cough
  - ☐ Tuberculosis
  - ☐ Tumor or Cancerous Growth
  - ☐ Radiation Treatment or Chemotherapy
  - ☐ Persistent Swollen Neck Glands
  - ☐ Alcohol or Chemical Dependency
  - ☐ Smoke or Chew Tobacco
  - ☐ Other condition doctor should know

- Do you wish to talk with the doctor privately about anything? .... ☐ Yes ☐ No

Patient Signature: ______________________________ Date: _________________

Privacy Practices

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor to use and disclose my personal information to carry out treatment, payment, and other necessary healthcare operations.

Signature: ______________________________ Date: ______________

Fees & Payments

I understand and agree that all fees are the responsibility of the patient and/or responsible party, due and payable within 90 days from the day of service, irrespective and regardless of any insurance claims or other anticipated benefits. Account balances older than 90 days will be subject to interest charges in the amount of 18% per annum, and further subject to collection fees which would accrue should it become necessary to enlist an outside agency for collection services.

- Patient Signature: ______________________________ • Date: ____________
  (Parent or Guardian, if Minor)

I hereby authorize payment directly to Donald F. Cohen, D.D.S., Inc. of benefits due me for services provided by him and/or his representatives. I understand that I am financially responsible for the entire cost of services provided regardless of insurance coverage. I hereby authorize the release of any information acquired in the course of my treatment as may be necessary to process my insurance claim.

- Patient Signature: ______________________________ • Date: ____________
  (Parent or Guardian, if Minor)

Authorization for Release of Information to Family and/or Friends

- Patient Name: ______________________________ • Date of Birth: ____________

Houston Oral Surgery & Dental Implant Center is authorized to release protected health information about the above-named patient to the entities named below.

- ☐ Medical Information
- ☐ Results from Tests or X-rays
- ☐ Financial Information

- Family/Friend Name: ______________________________ • Phone: ____________
- Family/Friend Name: ______________________________ • Phone: ____________