

Melvin Cohen, D.D.S.

Restorative, Cosmetic & Implant Dentistry

16152 Beach Blvd. Suite 100
Huntington Beach, CA 92647
Ph(714)847-8501 ■ Fx(714)843-9111
www.MelvinCohenDDS.com

PATIENT CONFIDENTIAL INFORMATION

Name _____
FIRST MIDDLE LAST

Email Address _____

Address _____
STREET CITY STATE ZIP CODE

Home Phone (_____) _____ Cell Phone (_____) _____ Business Phone (_____) _____

Age _____ Date of Birth ____/____/____ Sex : Male Female Marital Status: M S D W

Social Security No. _____ CA Driver's Licence # _____

Occupation _____ Employer _____ How Long? _____

Employer's Address _____

In case of emergency call _____ (_____) _____
NAME PHONE

Referred to this office by _____

SPOUSE INFORMATION

Spouse's Name _____
FIRST MIDDLE LAST

Date of Birth _____ Social Security No. _____

Employer's Address _____
STREET CITY STATE ZIP CODE

Occupation _____ Employer _____ How Long? _____

Business Phone (_____) _____

DEPENDENT INFORMATION

Father _____ Address _____
FIRST LAST STREET CITY ZIP CODE

Mother _____ Address _____
FIRST LAST STREET CITY ZIP CODE

School Child Attends _____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (check one) Cash Check MasterCard Visa Discover

Fees are due when services are rendered unless prior arrangements have been made.

INSURANCE INFORMATION

Dental Insurance Company (primary) _____
NAME ADDRESS

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____

EMPLOYER _____ EFFECTIVE DATE _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

Dental Insurance Company (secondary) _____
NAME ADDRESS

INSURED PERSON'S NAME _____ BIRTHDATE _____ RELATIONSHIP _____

EMPLOYER _____ EFFECTIVE DATE _____ GROUP NO. _____ PLAN NO. _____ NAME OF UNION _____ LOCAL _____

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HEALTH HISTORY

PATIENT NAME: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

MEDICAL CARE

1. Are you in good health?	YES	NO
2. Date of last physical examination _____		
3. Are you now under the care of a physician? If so, what is the condition being treated? _____	YES	NO
4. Who is your physician? _____ Phone Number (_____)_____		
5. May we contact your physician? (if necessary)	YES	NO
6. Have you ever had a serious illness or operation? If so, what illness or operation? _____	YES	NO
7. Have you ever been hospitalized? If so, what was the problem? _____	YES	NO
8. Are you taking any prescribed medication? If so, what? _____	YES	NO
9. Are you taking any over the counter medication? If so, what? _____	YES	NO
10. Have you ever been pre-medicated with antibiotics for your dental treatment?	YES	NO
11. Are you sensitive or allergic to any drugs? If so, what? <input type="checkbox"/> Penicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Codiene <input type="checkbox"/> Other: _____	YES	NO
12. Have you ever taken Fen-Phan Redux Pondimin	YES	NO
13. Do you use any form of tobacco? If so, what? _____	YES	NO
14. (Women) Are you pregnant? If so, what is your expected due date? _____	YES	NO
15. (Women) Are you nursing?	YES	NO
16. (Women) Do you take birth control pills?	YES	NO
17. Have you ever had a hip or knee replaced? ...or any other joint replacement? If so, when? _____	YES	NO
18. Have you ever had and pins, screws, plates placed? If so, when? _____	YES	NO
19. Have you ever had a stent placed? If so, when and where? _____	YES	NO
20. Do you have a pace maker?	YES	NO
21. Do you have any disease, condition or problem not listed that you think we should know about? If so, what? _____	YES	NO
22. What is your pharmacy's name? _____ Phone Number (_____)_____		

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HEALTH HISTORY

PATIENT NAME: _____

Do you have or have you had any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Atrial defibrillator | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies or hives |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> AIDS Complex |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Artificial prosthesis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Drug addition |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> G.E. reflux/
persistent heartburn |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Rheumatic heart disease/
rheumatic fever | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Shunts | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood diseases | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Venereal disease |
| | <input type="checkbox"/> Fainting spells | |

DENTAL HISTORY

Reason for this visit _____

Chief Dental Complaint _____

Are you having pain at this time? YES NO

Date of last Dental Exam ____/____/____ Date of last teeth cleaning (prophylaxis) ____/____/____

Previous dentist _____ Date last treated ____/____/____

Any previous major dental treatment YES NO When _____

Are you interested in improving the appearance of your smile? YES NO

If so, what changes would you like to make? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

- | | | |
|---|--|---|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweet or pressure | <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Dental Floss |
| <input type="checkbox"/> Bleeding Gums. How long? _____ | <input type="checkbox"/> Unfavorable dental experience | <input type="checkbox"/> Inter dental stimulants |
| <input type="checkbox"/> Food Impaction | <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Water jet device |
| <input type="checkbox"/> Cleanching or grinding | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Disclosing tablets or solution |
| <input type="checkbox"/> Burning of tongue | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Fluide supplements |
| <input type="checkbox"/> Swelling or lumps in mouth | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Oral habits, i.e. fingernail biting, cheek biting, etc. | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Cigaretts, pipe or cigar smoking | |
| <input type="checkbox"/> Unusual sounds in ear while eating | <input type="checkbox"/> Texture of toothbrush _____ | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Frequency of brushing _____ | |

Is there anything else about having dental treatment that bothers you? _____

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To All Our Patients:

We understand that in our busy world rescheduling an appointment may, on occasion, be necessary. However, we request that if you must reschedule at least a 24-hour notice be given.

There will be a full charge for missed appointments or rescheduled appointments with less than a 24-hour notice given. Our answering machine does not take any cancellations. They must be done by the front office.

Sincerely,

Dr. Melvin Cohen D.D.S

PATIENT SIGNATURE

DATE

DOCTOR SIGNATURE

DATE

CONSENT

The Undersigned hereby authorizes Dr. Cohen to perform all the necessary diagnosis of the patient's dental or oral facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic.

As a courtesy to our patients, we will bill your dental insurance for you. However, the charges incurred in our office are the patient's full responsibility.

All accounts 90 days past due will incur a late charge of 1.5 percent per month (18% per year).

There will be a \$35.00 charge for all returned checks.

There will be a charge if a patient changes their appointment without a 24-hour notice.

PATIENT SIGNATURE

DATE

DOCTOR SIGNATURE

DATE

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the Notice of
Privacy Practices for this office.

PRINT NAME

SIGNATURE

DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on May 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

- Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

NOTICE OF PRIVACY PRACTICES ...continued

- Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member; your persona; representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.
- Required by Law:** We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information of inmates or patients under certain circumstances.
- Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

- Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will not charge you for a copy of your health information. If you request an alternative format other than photocopy, we may charge a cost-based fee for providing your health information in that alternative format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
- Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Restriction:** You have the right to request that we place additional restrictions on our disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (**You must make your request in writing**). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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NOTICE OF PRIVACY PRACTICES ...amendment

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Melvin Cohen, DDS
Attn: Office Manager
16152 Beach Blvd., #100
Huntington Beach, CA 92647

Telephone: (714) 847-8501 **Fax:** (714) 843-9111

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