# Melvin Cohen, D.D.S.

Restorative, Cosmetic & Implant Dentistry

7677 Center Ave. #305
Huntington Beach, CA 92647
www.melvincohendds.com
714-847-8501

## 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 DW

Social Security No.________________________ CA Driver's License # __________________________

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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## HEALTHHISTORY

PATIENT NAME: ______________________________

Belowisalistofconditionswhichmayseemunrelatedtothe purpose ofyourappointment.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? YES NO
   If so, what is the condition being treated? ______________________________
4. Who isyour physician? ______________________________
   Phone Number (_____)__________________
5. May we contact your physician? (if necessary) YES NO
6. Haveyoueverhadaserious illness oroperation? YES NO
   If so, what illness or operation? ______________________________
7. Have you ever been hospitalized? YES NO
   If so, what was the problem? ______________________________
8. Are you taking any prescribed medication? YES NO
   If so, what? ______________________________
9. Are you taking any over the counter medication? YES NO
   If so, what? ______________________________
10. Have you ever been pre-medicated with antibiotics for your dental treatment? YES NO
11. Are you sensitive or allergic to any drugs? YES NO
    If so, what? ☐ Penicillin ☐ Erythromycin ☐ Codeine ☐ Other: ______________________________
12. HaveyouevertakenFen-PhenReduxPondimin YES NO
13. Do you use any form of tobacco? YES NO
    If so, what? ______________________________
14. (Women) Are you pregnant? YES NO
    Ifso,whatisyourexpectedduedate? ______________________________
15. (Women) Are you nursing? YES NO
16. (Women) Do you take birth control pills? YES NO
17. Haveyou ever had a hip or knee replaced? ...or any other joint replacement? YES NO
    If so, when? ______________________________
18. Have you ever had and pins, screws, plates placed? YES NO
    If so, when? ______________________________
19. Haveyoueverhadastent placed? YES NO
    If so, when and where? ______________________________
20. Do you have a pacemaker? YES NO
21. Do you have any disease, condition or problem not listed that you think we should know about? YES NO
    If so, what? ______________________________
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?

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

## DENTAL HISTORY

Reason forthis 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?

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

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 __________

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# 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 2.0 percent per month (24% 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)

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

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# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUTYOU MAY BE USED AND DISCLOSED AND HOWYOU CAN GET ACCESS TOTHISINFORMATION

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 activates, 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.

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## 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 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 supportt 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
7677 Center Ave. #305
Huntington Beach,
CA 92647

Telephone: (714) 847-8501