Dr. Gettys Cohen Jr., DDS, PA & Dr. Kennon A. Woods DDS

14 Noble Street Smithfield NC 27577

Phone : 919-934-5778

www.cohenwoodsdentistry.com

Registration and Health History

Patient Information

Today's Date: _____ Reason for this visit: _____

Patient's Name: _____ DOB: _____ SS#: _____
(Last) (First) (MI)

Address: _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

DL # _____ Sex: _____ Marital Status: _____

Employer: _____ Email: _____

Person to contact in an emergency _____ Home # _____ Work # _____

If patient is a minor, give parent or guardian's name _____

How did you hear about our office? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____

Insured's SS#: _____ DOB: _____

Insured's Address (if different than above): _____

City _____ State _____ Zip _____

Insured's Employer: _____ Insurance Company: _____

Claims Address:

_____

Phone #: _____ Group #: _____ Effective Date of coverage: _____

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me.

Signed _____ **Date** _____

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your Dental Health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

How long since you have seen a dentist? _____ Last **complete** exam date: _____

Date you last had x-rays taken: _____ What is your major dental concern? _____

Previous Dentist's Name: _____ City _____ State _____

Y N If we could offer you a simple, effective way of whitening your teeth, would you be interested?
Y N If you could change one thing about your smile or dental health would you, and what would it be?

_____

Y N Are you aware of clenching or grinding your teeth?
Y N Do you have frequent migraines, headaches, earaches or neck pain?
Y N Do your jaw joints (TMJ) pop, click or have a grinding sound?
Y N Do you experience pain in your jaw joints (TMJ)?
Y N Are your teeth sensitive to hot, cold, sweets or pressure? (circle)
Y N Have you had any periodontal (gum) treatments?
Y N Do your gums bleed, feel tender or irritated?
Y N Have you ever had or been evaluated for orthodontic treatment?
Y N Have you ever had a serious/difficult problem associated with any previous dental work?
Y N Do you have bad breath or has anyone ever told you that you have bad breath?
Y N Do you snore or do you feel tired after a full nights sleep?

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

_____ Fear of pain _____ Lack of Concern _____ Cost of Treatment _____ Missing Work Time

Medical History

Y N Do you have any current health problems? Explain _____

Y N Are you under a Physician's care now? Explain _____

Y N Are you pregnant? Y N Do you smoke?

Family Physician (or OBGYN) _____ Phone # _____

List all medications you're currently taking _____

Circle any of the following medications to which you are allergic or have ever reacted adversely

Aspirin Codeine Local Anesthetic Nitrous Oxide Erythromycin Penicillin Latex Sulfa Other _____

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

__ Heart disease or attack
__ Angina Pectoris
__ High Blood Pressure
__ Heart Murmur
__ Rheumatic Fever
__ Congenital heart failure
__ Mitral Valve Prolapse (MVP)
__ Artificial heart valve
__ Heart Pacemaker
__ Heart surgery
__ Artificial joints (hip, knee)
__ Anemia
__ Stroke
__ Hepatitis A (infectious)
__ Hepatitis B (serum)
__ AIDS/ARC/HIV Positive
__ Liver Disease
__ Blood Transfusion
__ Hemophilia Fever
__ blisters Epilepsy or
__ seizures
__ Nervousness
__ Psychiatric treatment
__ Pain in Jaw joints
__ Emphysema
__ Tuberculosis (TB)
__ Asthma
__ Hay Fever Sinus
__ trouble Allergies
__ or hives
__ Cortisone medicine
__ Thyroid disease
__ Radiation treatment
__ Arthritis
__ Chemotherapy (if so when?) from_____ to _____
__ Blood disorders causing increased clotting times
__Ulcers
__Kidney Trouble
__Venereal Disease
__Bruise easily
__Cosmetic Surgery
__Glaucoma (type_____)
__Drug addiction
__Alcoholism
__Osteoporosis

Y N Do you have diabetes? If yes, please specify what type _____; Date of diagnosis _____;
What was your most recent blood sugar reading? _____; Date last tested _____

Y N Have you or are you taking any of the following medications (Bis-Phosphonates) Aredia Zometa Fosamax Actonel or Boniva?
(If "Yes" please specify dates and reason for taking from _____ to _____, for _____)

Y N Have you or are you taking any of the following medications (SSRI's) Lexapro Prozac Paxil Zoloft Luvox Effexor
(If "Yes" please specify dates and the reason for taking from_____ to _____, for_____)

Is there any other medical or dental information or experiences that you feel we should know about?_____

_____

Patient Signature or Parent/Guardian of child: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have been given the opportunity to receive Cohen Woods Dentistry Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by Cohen Woods Dentistry, my individual rights and the Cohen Woods Dentistry legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that Cohen Woods Dentistry is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorizations.
- My individual rights with respect to protected health information and how I can exercise those rights in relationship to:
- The right to complain to Cohen Woods Dentistry and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
- The right to request restrictions of certain uses and disclosures of my protected health. However, I understand that Cohen Woods Dentistry does not have to agree to honor my requested restrictions.
- The right to receive confidential communications of protected health information
- The limited right to inspect and copy certain protected health information.
- The right to request to amend protected health information.
- The right to request an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from Cohen Woods Dentistry upon request.

I also understand the Cohen Woods Dentistry reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.

Signature: _____ Date: _____

Relationship to Patient {if signed by a personal representative of patient} _____

If you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below.

My treatment and account status may be discussed with _____(name)

_____(relationship). _____date