Payam Cohen D.D.S., P.C.

Family, Cosmetic & Implant Dentistry

71-06 110th Street, Suite 1F

Forest Hills, NY 11375

Phone: (718) 793-6669

Date: _____

Patient's Name: _____ Birthdate: _____

Last First Initial

DENTAL HISTORY

Reason for Today's visit: _____

Date of last dental care: _____ Date of last dental X-rays_____

Check (√) if you have had problems with any of the following:

□ Bad Breath	□ Grinding teeth	□ Sensitivity to hot
□ Bleeding gums	□ Loose teeth	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Have you ever had any serious illness or operations? _____ If yes, please describe: _____

Have you ever had any blood transfusion? □ Yes □ No If yes, give approximate date(s):_____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (√) **if** you have or have had any of the following:

□ AIDS	□ Cortisone Treatment	□ Hepatitis A, B, C	□ Rheumatic Fever
□ Anemia	□ Cough, Persistent	□ High Blood Pressure	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Cough up Blood	□ HIV Positive	□ Shortness of Breath
□ Artificial Heart Valves	□ Diabetes	□ Jaw Pain	□ Skin Rash
□ Artificial Joints	□ Epilepsy	□ Kidney Disease	□ Stroke
□ Asthma	□ Fainting	□ Liver Disease	□ Swelling of Ankles
□ Back Problems	□ Glaucoma	□ Mitral Valve Prolapse	□ Thyroid Problems
□ Blood Disease	□ Headaches	□ Nervous Problems	□ Tobacco Habits
□ Cancer	□ Heart Murmur	□ Pacemaker	□ Tonsillitis
□ Chemical Dependency	□ Heart Problems:	□ Psychiatric Treatment	□ Tuberculosis
□ Chemotherapy	Describe: _____	□ Radiation Treatment	□ Ulcer
□ Circulatory Problems	□ Hemophilia	□ Respiratory Disease	□ Venereal Disease

MEDICATION

List the medication you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Address: _____

_____

Phone: _____

ALLERGIES

□ Aspirin	□ Penicillin
□ Barbiturates (Sleeping pills)	□ Sulfa
□ Codeine	□ Other _____
□ Local Anesthetic	

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____