THE PRACTICE | BEVERLY HILLS BOUTIQUE DENTAL

Office of Dustin Cohen, DMD, Stacey Cohen, DMD, Andrew Frank, DDS

MEDICAL HISTORY

FULL NAME		D.O.B.		SEX	
MEDICAL PHYSICIAN		DATE OF LAST MEDICAL VISIT			
HOW IS YOUR GENERAL HEALTH?		HEIGHT		WEIGHT	

PLEASE CHECK THE BOX TO THE LEFT IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS/HIV	☐ EPILEPSY	☐ RADIATION TREATMENT
☐ ALZHEIMER'S OR OTHER DEMENTIA*	☐ FAINTING OR DIZZINESS	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ GLAUCOMA	☐ RHEUMATIC FEVER
☐ ARTHRITIS, RHEUMATISM	☐ HEADACHES	☐ SCARLET FEVER
☐ ARTIFICIAL HEART VALVES	☐ HEART MURMUR	☐ SEXUALLY TRANSMITTED DISEASE
☐ ARTIFICIAL JOINTS	☐ HEART PROBLEMS	☐ SHORTNESS OF BREATH
☐ ASTHMA	☐ HEPATITIS TYPE ____	☐ SINUS TROUBLE
☐ BACK PROBLEMS	☐ HERPES	☐ SKIN RASH
☐ BLEEDING, DELAYED CLOTTING	☐ HIGH BLOOD PRESSURE	☐ SPECIAL DIET
☐ BLOOD DISEASE	☐ JAUNDICE	☐ STROKE
☐ CANCER	☐ JAW PAIN	☐ SWOLLEN FEET OR ANKLES
☐ CHEMICAL DEPENDENCY	☐ KIDNEY DISEASE	☐ SWOLLEN NECK GLANDS
☐ CHEMOTHERAPY	☐ LIVER DISEASE	☐ THYROID PROBLEMS
☐ CIRCULATORY PROBLEMS	☐ LOW BLOOD PRESSURE	☐ TONSILITIS
☐ CONGENITAL HEART LESIONS	☐ MITRAL VALVE PROLAPSE	☐ TUBERCULOSIS
☐ CORTISONE TREATMENTS	☐ NERVOUS PROBLEMS	☐ TUMOR OR GROWTH ON HEAD OR NECK
☐ COUGH, PERSISTENT OR BLOODY	☐ OSTEOPOROSIS	
☐ DIABETES	☐ PACEMAKER	☐ ULCER
☐ EMPHYSEMA	☐ PSYCHIATRIC CARE*	☐ WEIGHT LOSS, UNEXPLAINED

* IF THERE IS ANOTHER INDIVIDUAL THAT SHOULD BE CONSULTED REGARDING TREATMENT DECISIONS, PLEASE PROVIDE THEIR NAME AND CONTACT INFO

DO YOU HAVE ANY OTHER CONDITIONS NOT LISTED ABOVE? YES NO

IF YES, PLEASE EXPLAIN

HAVE YOU HAD SURGERY OR BEEN HOSPITALIZED IN THE PAST YEAR? YES NO

IF YES, PLEASE EXPLAIN

HAVE YOU EVER BEEN INSTRUCTED TO TAKE ANTIBIOTICS BEFORE A DENTAL APPOINTMENT? YES NO

IF YES, PLEASE TELL US WHICH ANTIBIOTIC AND FOR WHAT CONDITION

WOMEN	ARE YOU PREGNANT?	YES NO	DUE DATE		ARE YOU NURSING?	YES NO

CONTINUED ON BACK

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ALLERGIES

	ASPIRIN		CODEINE		LATEX		PENICILLIN
	BARBITUATES		IODINE		LOCAL ANESTHETIC		SULFA
OTHERS							

MEDICATIONS

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING:		

TO BE TAKEN AT APPOINTMENT

BLOOD PRESSURE (mmHG)		PULSE (BPM)	

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Reservation Policy: Each appointment is a reservation with one of our Doctors or Hygienists and we strive to be punctual because we value our patients' time. We ask for a minimum of **24 hours notice** to cancel or reschedule any reservations and to avoid a Missed Reservation Fee. For appointments over 2 hours long or scheduled outside of our normal business hours, we request a 25% non-refundable deposit to secure your reservation.

PATIENT'S SIGNATURE		DATE	
DENTIST'S SIGNATURE		DATE	

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WELCOME

FULL NAME		D.O.B.		SEX	
PREFERRED NAME		SSN			
ADDRESS		CITY, STATE		ZIP	
HOME PHONE		BUSINESS/CELL PHONE			
MARITAL STATUS		SPOUSE'S NAME			
OCCUPATION		REFERRED BY			
EMAIL ADDRESS					
EMERGENCY CONTACT		RELATIONSHIP		PHONE	

HOW WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENT?		PHONE CALL		TEXT MESSAGE		EMAIL

DENTAL HISTORY

REASON FOR TODAY'S VISIT			
FORMER DENTIST		CITY, STATE	
DATE OF LAST VISIT		DATE OF LAST X-RAYS	

PLEASE CHECK THE BOX TO THE LEFT IF YOU HAVE HAD ANY OF THE FOLLOWING:

	BAD BREATH		FOOD COLLECTION BETWEEN TEETH		ORTHODONTIC TREATMENT
	BLEEDING GUMS		FOREIGN OBJECTS – E.G., PIERCINGS		PAIN AROUND EAR
	BLISTERS ON LIPS OR MOUTH		GRINDING TEETH		PERIODONTAL TREATMENT
	BURNING SENSATION ON TONGUE		GUMS SWOLLEN OR TENDER		SENSITIVITY TO COLD
	CHEW ON ONE SIDE OF MOUTH		JAW PAIN OR TIREDNESS		SENSITIVITY TO HEAT
	CIGARETTE, PIPE, OR CIGAR SMOKING		LIP OR CHEEK BITING		SENSITIVITY TO SWEETS
	CLICKING OR POPPING JAW		LOOSE TEETH OR BROKEN FILLINGS		SENSITIVITY WHEN BITING
	DRY MOUTH		MOUTH BREATHING		SORES OR GROWTHS
	FINGERNAIL BITING		MOUTH PAIN, BRUSHING		

HOW OFTEN DO YOU BRUSH?		HOW OFTEN DO YOU FLOSS?	

PATIENT AGREEMENT

1	I understand that all outstanding balances are due at the time services are rendered.
2	If payment is not received within 30 days, or if I designate prior, my credit card on file may be charged for any outstanding balances due.
3	**Reservation Policy**: Each appointment is a reservation with one of our Doctors or Hygienists and we strive to be punctual because we value our patients' time. We ask for a minimum of **24 hours notice** to cancel or reschedule any reservations and to avoid a Missed Reservation Fee. For appointments over 2 hours long or scheduled outside of our normal business hours, we request a 25% non-refundable deposit to secure your reservation.

PLEASE RETURN THIS FORM WITH: 1) A FORM OF GOVERNMENT-ISSUED ID, 2) CREDIT CARD, AND 3) INSURANCE CARD

PATIENT'S SIGNATURE		DATE	
DENTIST'S SIGNATURE		DATE	

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PERSONALIZE YOUR VISIT (OPTIONAL)

FULL NAME			D.O.B.		
PREFERRED NAME					
PLEASE SELECT FROM THE FOLLOWING COMPLIMENTARY OPTIONS					
BLANKET		GLUTEN-FREE PRODUCTS		PILLOW	
BOTTLE OF WATER		LIP BALM		WARM TOWELETTE	
PREFERRED POLISHING PASTE FLAVOR					
GLUTEN-FREE PLAIN		GLUTEN-FREE MINT		BUBBLE GUM	
CHERRY		SURPRISE ME!			
ENTERTAINMENT					
TV		INTERNET RADIO		EARPHONES	
EARPLUGS		NONE			
PREFERRED APPOINTMENT TIME					
EARLY MORNING		LATE MORNING		EARLY AFTERNOON	
LATE AFTERNOON		FLEXIBLE			
PREFERRED APPOINTMENT DAY					
MONDAY		TUESDAY		WEDNESDAY	
THURSDAY		FRIDAY		SATURDAY	

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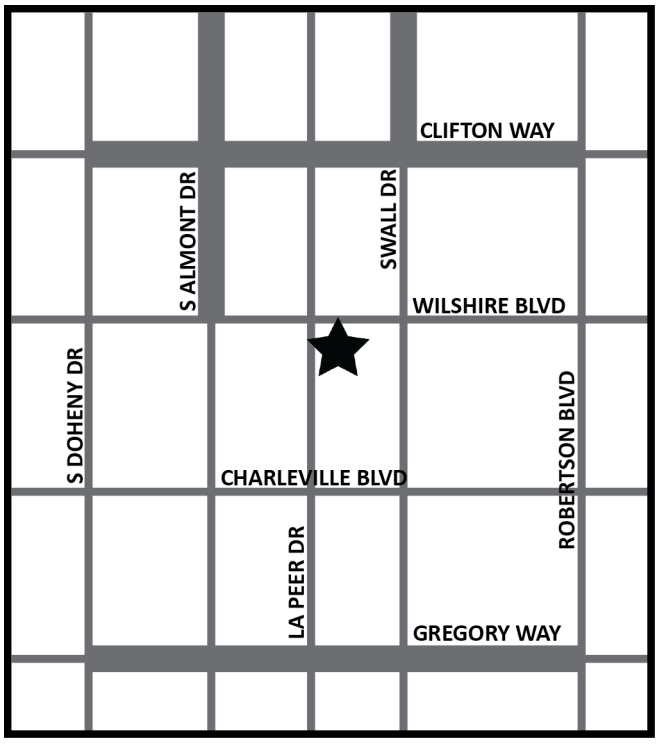

PARKING

Underground valet or street parking is available. Thick lines on the above map indicate streets with free 2-hour parking. *Subject to change without notice.*