WELCOME *Sheet*

Thank you for choosing Cooper Dental! In order for us to provide you with the best possible care we ask that you fill out this form. If you have any questions or need assistance, please don't hesitate to ask!

Patient Information (Confidential)

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY/ZIP: _____ EMAIL: _____

SS#/SIN: _____ PHONE: _____

IF STUDENT, NAME OF SCHOOL/ COLLEGE: _____

_____

Do you have dental insurance? ☐ Yes ☐ No

* If yes, please bring your insurance card to your first appointment.

Whom may we thank for referring you? _____

Emergency Contact

NAME: _____ PHONE: _____

RELATIONSHIP: _____

Patient Medical History

CURRENT PHYSICIAN OR OFFICE: _____

PHONE: _____

Yes	No	
☐	☐	1. Are you under medical treatment now?
☐	☐	2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____
☐	☐	3. Do you use tobacco?
☐	☐	4. Do you use controlled substances?
☐	☐	5. Have you ever taken Fen-Phen/ Redux?
☐	☐	6. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphonates?
☐	☐	7. Are you taking any medication(s) including non prescription medications? If yes, please list:

8. Some health conditions (e.g artificial heart valves, joint replacements, compromised immune systems) require antibiotics prior to dental cleanings and treatment.

Yes	No	
☐	☐	a) Have you required premedication for dental visits in the past?
☐	☐	b) Do you have artificial heart valves, joint, hip, or knee? If yes, please explain: _____

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9. Do you have or have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	**High Blood Pressure**	☐	☐	**Liver Disease**	☐	☐	**Kidney Diseases**
☐	☐	**Angina**	☐	☐	**Asthma**	☐	☐	**Stomach Troubles**
☐	☐	**Tuberculosis**	☐	☐	**Arthritis**	☐	☐	**AIDS or HIV Infection**
☐	☐	**Heart Attack**	☐	☐	**Heart Trouble**	☐	☐	**Ulcers**
☐	☐	**Low Blood Pressure**	☐	☐	**Thyroid Problem**	☐	☐	**Radiation Therapy**
☐	☐	**Joint Replacement**	☐	☐	**Chest Pains**	☐	☐	**Rheumatic Fever**
☐	☐	**Respiratory Problems**	☐	☐	**Heart Disease**	☐	☐	**Anemia**
☐	☐	**Epilepsy/ Convulsions**	☐	☐	**Easily Winded**	☐	☐	**Glaucoma**
☐	☐	**Cardiac Pacemaker**	☐	☐	**Mitral Valve Prolapse**	☐	☐	**Stroke**
☐	☐	**Emphisema**	☐	☐	**Leukemia**	☐	☐	**Heart Murmur**
☐	☐	**Hepatitis/ Jaundice**	☐	☐	**Hay Fever/ Allergies**	☐	☐	**Fainting/ Seizures**
☐	☐	**Cancer**	☐	☐	**Sexually Transmitted Disease**	☐	☐	**Other:**_____

10. a) Do you have Sleep Apnea?

☐ Yes ☐ No

b) If yes, do you use a CPAP Machine?

☐ Yes ☐ No

11. Do you have diabetes?

☐ Type 1 ☐ Type 2 ☐ No

12. Women Only:

a) Are you pregnant or think you may be pregnant?

☐ Yes ☐ No

b) Are you nursing?

☐ Yes ☐ No

c) Are you taking oral contraceptives?

☐ Yes ☐ No

13.Are you allergic to or have you had any reactions to the following?

Yes	No	
☐	☐	**Local Anesthetics (e.g. Novocain)**
☐	☐	**Penicillin or any other Antibiotics**
☐	☐	**Sulfa Drugs**
☐	☐	**Barbiturates**
☐	☐	**Sedatives**
☐	☐	**Iodine**
☐	☐	**Aspirin**
☐	☐	**Any Metals (e.g. nickel, mercury, etc)**
☐	☐	**Latex Rubber**
☐	☐	**Any other allergies?**

If yes, please list:_____

14.Do you have a persistent cough or throat clearing not associated with a known illness lasting more than 3 weeks? ☐ Yes ☐ No

15. a)Do you experience anxiety and/or fear of the dentist? ☐ Yes ☐ No

b)*If yes, is there anything we can do to help you feel more comfortable in our office?*

16. Is there anything else you'd like to share with us to help our team provide you with the best possible care?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or parent/guardian if minor) *Date*