Mitchell Cohen Orthodontics
Priceless Smiles at Affordable Fees!
225 Scranton Carbondale Highway, Scranton, PA 18508 | P/ 570.346.2132 | www.thanksdrcohen.com

PATIENT HEALTH HISTORY/CONSENT TO TREATMENT

Patient Name _____ Date _____

Last Dental Exam_____ Last Physical Exam _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Is the patient UNDER PHYSICIANS CARE, other than periodic exam? ❑ Yes ❑ No
- Is the patient receiving any MEDICATIONS or DRUGS? ❑ Yes ❑ No
- Is patient ALLERGIC TO PENICILLIN or other drugs? ❑ Yes ❑ No
- Has the patient ever had RHEUMATIC FEVER? ❑ Yes ❑ No
- Does the patient have and HEART ABNORMALITIES? ❑ Yes ❑ No
  (including heart murmur, congenital heart lesions, mitral valve prolapsed, prosthetic valve replacement, etc.)
- Does the patient have a PROSTHETIC OR ARTIFICAL JOINT? ❑ Yes ❑ No
- Has the patient ever been HOSPITALIZED? ❑ Yes ❑ No
- Has the patient ever had SURGERY? ❑ Yes ❑ No
- Does the patient have IMPAIRED PHYSICAL COORDINATION? ❑ Yes ❑ No
- Are there any EMOTIONAL or BEHAVIORAL PROBLEMS? ❑ Yes ❑ No
- Has the patient received and INJURY to the face or DENTITION? ❑ Yes ❑ No
- Does the patient suffer from ringing or clicking in the EARS? ❑ Yes ❑ No
- Does the patient suffer from chronic HEADACHE or FACIAL PAIN ❑ Yes ❑ No
- Does the patient have, or is the patient at risk for and CONTAGIOUS or
- LIFE THREATENING diseases? (including hepatitis, AIDS, etc.) ❑ Yes ❑ No
- Is the patient PREGNANT or PLANNING PRENANCY? ❑ Yes ❑ No

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Anemia ❑ Yes ❑ No	*Hearing Problems* ❑ Yes ❑ No	*Malignancies* ❑ Yes ❑ No
Asthma ❑ Yes ❑ No	*Heart Abnormalities* ❑ Yes ❑ No	*Pneumonia* ❑ Yes ❑ No
Measles ❑ Yes ❑ No	*Kidney Disorders* ❑ Yes ❑ No	*Mumps* ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	*Liver Disorders* ❑ Yes ❑ No	*Mononucleosis* ❑ Yes ❑ No
Epilepsy ❑ Yes ❑ No	*TMJ/Joint Dysfunction* ❑ Yes ❑ No	*Finger Sucking* ❑ Yes ❑ No
Fainting ❑ Yes ❑ No	*Nasal Allergy* ❑ Yes ❑ No	*Speech Problems* ❑ Yes ❑ No
Bladder Infection ❑ Yes ❑ No	*Convulsions* ❑ Yes ❑ No	*Chicken Pox* ❑ Yes ❑ No

Has the patient suffered from any condition not covered above? _____

PLEASE INFORM US OF ANY CHANGES IN THE HEALTH HOSTORY, ESPECIALLY IF PATIENT PREGNANCY OCCURS DURING TREATMENT SO X-RAY EXPOSURE IS LIMITED.

To the best of my knowledge the above information is complete and correct.

I acknowledge that questions regarding the orthodontic treatment plan have been answered to my satisfaction and request orthodontic treatment for _____

Signature of PATIENT/PARENT/GAUARDIAN _____

Signature of DOCTOR _____