



VANESSA M. ADOLF, D.M.D.

RICHARD F. COHEN, D.D.S.

Title _____ Last Name _____ First Name _____ MI _____ Nickname _____

DOB ____/____/____ Gender _____ SSN _____ Marital Status _____

Home Address _____

Employer Name _____ Occupation _____

Home phone # _____ Cell phone # _____

May we call you at work? Y/N Work Phone # _____ E-mail Address _____

How would you like us to confirm your appointments? (circle one) Home Phone # Cell Phone # E-Mail

In case of an emergency, please provide name and phone number of a close relative or friend not living with you:

Name _____ Relationship to patient _____ Telephone # _____

Person Responsible for Fee (if other than patient):

Name _____ SSN _____ DOB: ____/____/____

Relationship _____ Address _____ Phone # _____

Date of last dental visit: ____/____/____ Reason for today's visit: _____

Are there any changes you would like to make to your smile? Y/N

How did you hear about our office? _____

Health Information:

Please list all medications you are currently taking (prescription and over the counter):

Are you currently taking Coumadin or any other blood thinners including aspirin? Y/N

Do you need antibiotic premedication prior to dental treatment? Y/N

Females: Are you currently pregnant? Y/N

Are you taking bisphosphorate medication? Y/N

Are you allergic to Penicillin? Y/N Are you allergic to latex? Y/N

Please list all allergies: None or _____

