

**Steven M. Cohen, DMD, MSD**  
*Practice limited to Orthodontics for Children and Adults*  
**Patient Information**

Patient's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Cell Phone Provider \_\_\_\_\_ E-mail address \_\_\_\_\_  
 You may contact me via text message (\*standard text messaging rates apply)  
Patient's School or Employer \_\_\_\_\_  
Patient's Dentist \_\_\_\_\_ Patient's Physician \_\_\_\_\_  
Who may we thank for referring you to this office? \_\_\_\_\_  
If patient is a minor, give parent's or guardian's name \_\_\_\_\_  
Patient's hobbies or interests \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Residence \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Cell Phone Provider \_\_\_\_\_ E-mail address \_\_\_\_\_  
 You may contact me via text message (\*standard text messaging rates apply)  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
**Spouse's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Spouse's Address \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. \_\_\_\_\_ Insured DOB \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_  
Complete Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Signature (Parent's signature if minor) \_\_\_\_\_  
Updates (date & initial) \_\_\_\_\_