

# WELCOME

**T**he benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you. ☺

Richard Cohen, D.M.D., 178 Newark Avenue, Jersey City, NJ 07302, (201) 332-0403

## About You

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Pager/Car #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Employer: \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

## Neighbor or Relative not living with you

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

## Spouse Information

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

## Insurance Information

**Primary Insurance** Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No Medical Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No Medical Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

CONTINUED ON BACK

