

# DMD Patient Scheduling Form- (must be returned to office to start registration process)

E-mail = [directmobiledentistry@gmail.com](mailto:directmobiledentistry@gmail.com)

Phone: 770-883-6868

Fax: 770-393-9757

1. Facility: \_\_\_\_\_ Date of Visit: \_\_\_\_\_
2. Patient Name: \_\_\_\_\_ (include middle initial) Room # \_\_\_\_\_
3. Patient's Date of Birth (DOB): \_\_\_\_\_
4. Responsible Party: (Financial Power of Attorney- POA) Name: \_\_\_\_\_
5. Relation to Patient: \_\_\_\_\_
6. Billing Address of Financial POA to send statement: \_\_\_\_\_
7. Credit Card # (Visa MC Disco Am/Ex) \_\_\_\_\_ Exp: \_\_\_\_\_  
*A 3% finance charge is applied when using credit cards* CVV: \_\_\_\_\_
8. The best phone number for Dr. Cohen to reach POA during the appointment : (H) (W) (C) \_\_\_\_\_
9. Alternate Number if we cannot reach you at first number: (H) (W) (C) \_\_\_\_\_
10. Allergies: \_\_\_\_\_  
(Ex: Penicillin, Mycins, Sulfa, Latex, Anesthetic Etc....)
11. Any Joint replacements? (Knee,Hip,Shoulder) or any pins,plates or rods? \_\_\_\_\_ Date of surgery \_\_\_\_\_
12. Any of the following: Heart Murmur , Pacemaker , Atrial Fibrillation (A-Fib) , Mitral Valve Prolapse (MVP)  
or Congestive Heart Failure (CHF)? \_\_\_\_\_
13. Any Strokes ? \_\_\_\_\_ When? \_\_\_\_\_
14. Any Stents, Ports, or Heart Bypass Surgery? \_\_\_\_\_ Date of Surgery?: \_\_\_\_\_
15. On Blood Thinners? \_\_\_\_\_ (Ex: Coumadin, Plavix, Warfarin, Eliquis , Pradaxa, Xarelto, etc....)
16. Take daily Aspirin ? \_\_\_\_\_ if so, is it .81 mg or 325 mg ? \_\_\_\_\_
17. Diabetic? \_\_\_\_\_ Insulin or Non-Insulin Dependent ? \_\_\_\_\_
18. Has patient tested positive for COVID 19 in the past 3 months ? Date : \_\_\_\_\_
19. Does Patient have his/her own teeth or dentures? \_\_\_\_\_

**The fees are:** Exam and Cleaning for a patient with full U/L Dentures is \$79  
Comprehensive exam and cleaning of Teeth (and partials) is \$179  
Exam only is \$75.  
New partial/denture is \$1500