NORTHGATE DENTAL
CATHERINE COX DDS

Patient Information

Dr. Catherine Cox, Northgate Dental
750 Las Gallinas Ave., San Rafael, CA 94903
Email: drcatherinejcox@gmail.com
Phone: (415) 479-2623

Date: _____

Last Name: _____ First Name: _____ ☒ Married ☒ Single ☒ Minor ☒ Male ☒ Female
Address: _____ City: _____ State: _____ Zip: _____
Email (Will be kept totally confidential): _____
Home Phone: (____) _____ Birthday: _____/_____/_____ SSN: _____ - ____ - _____
Work Phone: (____) _____ Cell Phone: (___) _____ Referred by: _____
If married, name of spouse: _____ Any family member ever been treated in our office: ☒ Yes ☒ No

Employer: _____ Address: _____ Phone: (____) _____
If full time student, name of school: _____. In what city: _____ Your grade: _____
If minor: Father's name: _____ Mother's name: _____ Guardian's name: _____
I live with: ☒ Father and mother ☒ Father ☒ Mother ☒ Guardian

Person to contact in an emergency (and outside of immediate family/ household): Name: _____
Address: _____ Daytime Phone: (____) _____
Relation to emergency contact: _____

Dental Insurance

Primary policy: Insurance company name: _____ Their phone: (____) _____
Subscriber is: ☒ Self ☒ Father ☒ Mother ☒ Spouse ☒ _____
Subscriber No: _____ Group No: _____
Employer company name: _____
If you not subscriber: Subscriber's full name: _____ SSN: _____ - ____ - _____
Subscriber's birthday: _____/_____/_____ Work phone: (____) _____

Secondary policy: Insurance company name: _____ Their phone: (____) _____
Subscriber is: ☒ Self ☒ Father ☒ Mother ☒ _____ Subscriber No: _____
Group No: _____ Employer company name: _____
If you not subscriber: Subscriber's full name: _____ SSN: _____ - ____ - _____
Subscriber's birthday: _____/_____/_____ Work phone: (____) _____

Method of Payment

Person responsible for account is: ☒ Self ☒ Parent ☒ Guardian
☒ _____

Method of payment:

- ☒ Insurance and any balance due is payable at time of service
- ☒ Payment in full at each appointment (by cash, check or credit card)
- ☒ I wish to discuss the dental Office Financial Policy

Service Charge:

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorneys' fees incurred to effect collection of this account or future outstanding balances.

Authorization

I hereby authorize payment directly to the dental Office of Dr. Catherine Cox of the group insurance payments otherwise payable to me. I understand that I am responsible for the cost of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical records or other information about my dental treatment to third party payors and/or other health professionals.

Signed: _____
Name Printed: _____
☒ Self ☒ Parent ☒ _____
Cal. Driver's Lic. No: _____
Date Signed: _____

Catherine Cox, D.D.S.

Patient Name: _____

Medical History

Important Note. Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health care problems that you may have, or medicine that you may be taking, could have an important interrelationship with the dentistry you will receive. These questions will help us treat you.

General Medical Condition

Previous Dentist: _____ ❒ Yes ❒ No

Are you under a physician's care now? ❒ Yes ❒ No

Ever been hospitalized or had major surgery? ❒ Yes ❒ No

Ever had a serious head or neck injury? ❒ Yes ❒ No

Do you take, or have you taken, Phen-Fen or redux? ❒ Yes ❒ No

Do you take, or have you taken, Bisphosphonates? ❒ Yes ❒ No

Woman: Are you pregnant/ trying to get pregnant ❒ Yes ❒ No

Woman: Are you taking oral contraceptives? ❒ Yes ❒ No

Are you on a special diet? ❒ Yes ❒ No

If yes, physician name: _____

If yes, explain: _____

If yes, explain: _____

Do you use controlled substances? ❒ Yes ❒ No

Do you use tobacco? ❒ Yes ❒ No

Woman: Are you nursing? ❒ Yes ❒ No

Allergies And Medication

Check if you are allergic to any of the following: ❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Local Anesthetics ❒ Other: _____

Please list any pills, medications or drugs you are taking: _____

_____

_____

If You Had Any of the Listed Illnesses, Check the Boxes

❒ AIDS/HIV Positive	❒ Cold Sores/Fever Blisters	❒ Glaucoma	❒ Liver Disease	❒ Sickle Cell Disease
❒ Alzheimer's Disease	❒ Congenital Heart Disorder	❒ Hay Fever	❒ Low Blood Pressure	❒ Sinus Trouble
❒ Anaphylazis	❒ Convulsions	❒ Heart Attack/Failure	❒ Leukemia	❒ Spina Bifida
❒ Anemia	❒ Cortisone Medicine	❒ Heart Murmur	❒ Lung Disease	❒ Stomach/Intestinal Disease
❒ Angina	❒ Diabetes	❒ Heart Pace Maker	❒ Mitral Valve Prolapse	❒ Stroke
❒ Arthritis/ Gout	❒ Drug Addiction	❒ Heart Trouble/Disease	❒ Osteoporosis	❒ Swelling of Limbs
❒ Artificial Heart Valve	❒ Easily Winded	❒ Hemophilia	❒ Pain In Jaw Joints	❒ Thyroid Disease
❒ Artificial Joint	❒ Emphysema	❒ Hepatitis A	❒ Parathyroid Disease	❒ Tonsillitis
❒ Asthma	❒ Epilepsy or Seizures	❒ Hepatitis B or C	❒ Psychiatric Care	❒ Tuberculosis
❒ Blood Disease	❒ Excessive Bleeding	❒ Herpes	❒ Radiation Treatments	❒ Tumors or Growths
❒ Blood Transfusion	❒ Excessive Thirst	❒ High Blood Pressure	❒ Recent Weight Loss	❒ Ulcers
❒ Breathing Problem	❒ Fainting Spells/Dizziness	❒ Hives or Rash	❒ Renal Dialysis	❒ Venereal Disease
❒ Bruise Easily	❒ Frequent Cough	❒ Hypoglycemia	❒ Rheumatic Fever	❒ Yellow Jaundice
❒ Cancer	❒ Frequent Diarrhea	❒ Irregular Heartbeat	❒ Rheumatism	❒ _____
❒ Chemotherapy	❒ Frequent Headaches	❒ Kidney Problems	❒ Scarlet Fever	❒ _____
❒ Chest Pains	❒ Genital Herpes	❒ Leukemia	❒ Shingles	❒ _____

Any serous illness not listed above: ❒ Yes ❒ No. If yes, state: _____

Medical Update And Accuracy

I have read my Medical History and confirm that it adequately states my past and present conditions.

Date	Exceptions	Patient's Signature	BP	Reviewed By
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____
_____	_____	_____	___/___	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Date: _____

_____

Signature of Patient, Parent Or Guardian