

## Patient Information

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: \_\_\_\_\_

# 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 on a special diet? ☐ Yes ☐ No  
 Are you under a physician's care now? ☐ Yes ☐ No      If yes, physician name: \_\_\_\_\_  
 Ever been hospitalized or had major surgery? ☐ Yes ☐ No      If yes, explain: \_\_\_\_\_  
 Ever had a serious head or neck injury? ☐ Yes ☐ No      If yes, explain: \_\_\_\_\_  
 Do you take, or have you taken, Phen-Fen or redux? ☐ Yes ☐ No      Do you use controlled substances? ☐ Yes ☐ No  
 Do you take, or have you taken, Bisphosphonates? ☐ Yes ☐ No      Do you use tobacco? ☐ Yes ☐ No  
 Woman: Are you pregnant/ trying to get pregnant? ☐ Yes ☐ No      Woman: Are you nursing? ☐ Yes ☐ No  
 Woman: Are you taking oral contraceptives? ☐ 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

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

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