

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

**Patient Information (please complete the following 2 pages)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Male  Female \*\*\*\*\*  Married  Single  Child  Other \_\_\_\_\_  
((If **CHILD** 12 years and under = Height \_\_\_\_\_ Weight \_\_\_\_\_))

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

**Health Information**

Previous Dentist: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

Artificial Joints  Heart Murmur  HIV/AIDS  \_\_\_\_\_  
 Diabetes  Hepatitis  Tuberculosis (TB)  
 Heart Problems  High Blood Pressure OTHER: \_\_\_\_\_

**Are you allergic to?**  Amoxicillin,  Erythromycin,  Latex,  Penicillin,  Sulfa,  Tetracycline,  
 Other \_\_\_\_\_

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been under the care of a physician during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Has your doctor ever said you need to be Pre-Medicated prior to dental treatment?  Yes  No

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

• List all medication you are currently taking (including over the counter drugs, vitamins, etc.....): \_\_\_\_\_

**WOMEN ONLY:** Are you Pregnant?  Yes  No; Nursing?  Yes  No

## Referral Information

Whom may we **thank for referring you** to our practice? \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient or  the person responsible for payment or insurance subscriber

Name of Insured: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_ Best time to call: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Relative or Friend not living with you

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_ (Cell): \_\_\_\_\_

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # or SSN \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # or SSN \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

Payment Method (please check one):  CREDIT CARD  CASH/CHECK  CARE CREDIT or Capital One (DFP)

***To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I hereby authorize Dr. Jared E. Cox to furnish any information to my insurance company concerning my care, and to receive assignment of dental benefits.***

Signature of patient, parent, guardian or guarantor of payment/responsible party \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Rev.1/2007