

WELCOME

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us — we will be happy to help.

NOTICE OF PRIVACY PRACTICES Patient Acknowledgement

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I acknowledge that I have reviewed a copy of Dr. Jared Cox's Notice of Privacy Practices.

Patient Name _____ Date ____/____/____

Signature: _____

Relationship to patient: _____

Tell Us About Your Child

Child's Name: _____
Last First MI

Nickname: _____ Male Female

Child's Birthdate: ____/____/____ Child's Age: ____

School: _____ Grade: ____

Child's Home #:(____) _____ SS #: _____

MEDICAID/Ins ID# _____

Child's Home Address: _____

_____ Apt.# _____

City State Zip Code

Who Is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? Yes No

Whom may we **Thank** for referring you?

Who is responsible for making appointments?

Name: _____

Wk #:(____) _____ Ext. _____

Home #:(____) _____

Cell #:(____) _____

Mother's Information: Guardian Step Mother

Name: _____ Birthdate: ____/____/____ SS #: _____

Wk #:(____) _____ Ext. _____ Home #:(____) _____ Cell #:(____) _____

Employer: _____ E-mail: _____

Father's Information: Guardian Step Father

Name: _____ Birthdate: ____/____/____ SS #: _____

Wk #:(____) _____ Ext. _____ Home #:(____) _____ Cell #:(____) _____

Employer: _____ E-mail: _____

(complete health information on the back of this form, thank you)

Insurance Information other than MEDICAID

Insurance Company _____ Ins. Phone # _____
Policy Holder Name: _____ SS #: _____ Birthdate: ____/____/____
Ins. Group # _____ Employer: _____

**PATIENT MEDICAL HISTORY
(ANSWER ALL QUESTIONS)**

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

- Asthma (**must bring inhaler to every dental visits**)
- 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

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ **Date:** / /
Signature of Patient (or parent, if minor)