PATIENT REGISTRATION AND MEDICAL HISTORY Date:_____

Date of Birth _____ Sex: M___ F___ Preferred Name _____
First Name _____ Middle Initial _____ Last Name _____
Single__ Married__ Divorced__ Separated__ Widowed__ SSN _____
Home Phone _____ Cell Phone _____
Email _____
Address_____
City_____ State_____ Zip Code_____
Employed by_____ Occupation_____
Business Address_____ Phone_____
Spouse/Parent Name_____ Spouse/Parent Phone _____
Spouse/Parent Social Security # _____ Date of Birth _____
Spouse/Parent Employed by_____ Occupation_____
Business Address_____ Phone_____
Who is responsible for this account? _____
In case of emergency_____ Phone_____
Whom can we thank for referring you? _____

* MEDICAL HISTORY *

Have you ever had any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Allergies	___	___	Growths	___	___	Mental Disorders
___	___	Anemia	___	___	Hay Fever	___	___	Mitral Valve Prolapse
___	___	Arthritis	___	___	Head Injuries	___	___	Nervous Disorders
___	___	Artificial Heart Valve	___	___	Hearing Impaired	___	___	Psychiatric Care
___	___	Artificial Joints	___	___	Heart Disease	___	___	Radiation Treatment
___	___	Asthma	___	___	Heart Murmur	___	___	Respiratory Disease
___	___	Back/Neck Problems	___	___	Heart Problems	___	___	Rheumatic Fever
___	___	Blood Disease	___	___	Hemophilia	___	___	Rheumatism
___	___	Cancer	___	___	Hepatitis	___	___	Scarlet Fever
___	___	Chemical Dependency	___	___	Herpes	___	___	Sinus Problems
___	___	Circulatory Problems	___	___	High Blood Pressure	___	___	Stomach Problems
___	___	Diabetes	___	___	HIV/AIDS	___	___	Stroke
___	___	Dizziness	___	___	HX of Endocarditis	___	___	Tuberculosis (TB)
___	___	Epilepsy	___	___	Jaundice	___	___	Tumors
___	___	Excessive Bleeding	___	___	Kidney Disease	___	___	Typhoid Fever
___	___	Fainting	___	___	Liver Disease	___	___	Ulcers
___	___	Glaucoma	___	___	Low Blood Pressure	___	___	Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ____
If so, what? _____
Are you taking any medications? ____ If so, what medications? **(Use back of sheet to list meds)**
Are you under the care of a Physician? ____ If so, please list physician's name and for what condition _____
Are you pregnant? _____ Nursing? _____ Do you use tobacco products? _____
Other medical history (i.e. surgeries, mental health, artificial replacements and dates, etc.)
_____
Have you ever been told to pre-medicate prior to dental work? _____
If so, for what and for how long? _____

DENTAL HISTORY

How long has it been since your last dental visit? _____

Do you experience anxiety when visiting the dentist? _____

How do you feel about your teeth? _____

If you could change one thing about your teeth, what would it be? _____

Would you like to know more about cosmetic dentistry? _____

Do you experience any pain when opening your mouth or chewing? _____

The medical and dental history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

*Date_____ Signature_____

***Assignment and Release**

I, the undersigned, have insurance with _____ and assign directly to
Name of Insurance Company
Dr. Cox all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
Date_____ Signature _____

***Financial Agreement**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. Dr. Cox cannot render services on the assumption that our charges will be paid by the insurance company.
Date_____ Signature _____

***Treatment Consent**

I, _____ do hereby request and authorize the dental staff to perform necessary dental services for myself or my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date_____ Signature _____