Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (____) _____ Alt. Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– O V E R –

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

John W. Cox, D.D.S. Patient Policies

- Missing a scheduled appointment without giving 48 hours prior notice will result in a broken appointment and an assessment of a $100 fee. After the 2nd broken appointment you will be dismissed from our practice.
- If you have a new address, phone number, insurance or any new health issues please make us aware prior to appointment.
- We must have a current phone number on file to confirm appointments or we will be forced to remove you from the schedule.
- All payments are expected at the beginning of each appointment.
- Small children must be supervised by a parent or guardian that can wait in our lobby with them.
- Turn cell phones off in operatories.
- Stealing will result in dismissal from our offices.
- Profanity, foul language or rude behavior is not permitted in our offices and will not be tolerated.
- Arguing with ANY of our office staff will result in dismissal from our offices.

I confirm that I have read and fully understand the above policies.

Signature:_____ Date:_____

be kind to yourself

Anesthetics

The length of time you experience numbness varies, depending on the type and amount of anesthetic you've received and the area that was anesthetized. While your mouth is numb, you'll want to be careful not to bite your cheek, lip or tongue. The numbness should subside within a few hours. If it doesn't, contact your dentist.

Bleeding

Your dentist may place a gauze pack on the extraction site to limit bleeding and confine the blood while clotting takes place. This gauze pack should be left in place for 30 to 45 minutes after you leave the dentist's office. Do not chew on the pack. There may be some bleeding or oozing after the pack is removed. If so, follow this procedure:

- Fold a piece of clean gauze into a pad thick enough to bite on. Dampen the pad with clean, warm water and place it directly on the extraction site.
- Apply moderate pressure by closing the teeth firmly over the pad. Maintain this pressure for about 30 minutes. If the pad becomes soaked with blood, replace it with a clean one as necessary.
- Do not suck on the extraction site.
- A slight amount of blood may leak from the extraction site until a clot forms. However, if heavy bleeding continues, call your dentist. (Remember, though, that a little bit of blood mixed with a lot of saliva can look like a lot of bleeding.)

The Blood Clot

After an extraction, a blood clot forms in the tooth socket. This clot is an important part of the normal healing process. You should avoid activities that might disturb the clot. Here's how to protect it:

- Do not smoke, or rinse your mouth vigorously, or drink through a straw for 24 hours. These activities create suction in the mouth, which could dislodge the clot and delay healing.
- Avoid alcoholic beverages or mouthwash containing alcohol for 24 hours.
- Do not clean the teeth next to the healing tooth socket for the rest of the day. You should, however, brush and floss your other teeth thoroughly. *Gently* rinse your mouth afterward.
- Limit strenuous activity for 24 hours after the extraction. This will reduce bleeding and help the blood clot to form.
- Sometimes the blood clot does not form in the first day or two after the extraction, or it forms but breaks down for some reason. The result is called *osteitis* or *dry socket*. This can be very painful and should be reported to your dentist. A dressing may be placed in the socket to protect it until the socket heals and to reduce any pain.

Medication

If your dentist has prescribed medication to control pain and prevent infection, use it only as directed. If the pain medication prescribed does not seem to work for you, do *not* increase the number of doses you take or decrease the interval between doses. Call your dentist. If you have any other difficulties with the medication, call your dentist. If you have prolonged or severe pain, swelling, bleeding, fever, nausea or vomiting, call your dentist immediately. If you cannot reach your dentist, go to a hospital emergency room.

Swelling and Pain

After a tooth is removed, you may have some discomfort and notice some swelling. You can help reduce swelling and pain by applying cold compresses to your face as directed by your dentist. An ice bag or cold, moist cloth can be used periodically. Your dentist may give you specific instructions on how long and how often to use a cold compress. Your dentist may also give you a cold pack to use on your way home from the office.

Diet

After the extraction, drink lots of liquids and eat soft, nutritious foods. Avoid hot liquids and alcoholic beverages. Begin eating solid foods the next day or as soon as you can chew comfortably. For the first few days, try to chew food on the side opposite the extraction site. When it feels comfortable, you could resume chewing on both sides of your mouth.

Cleaning Your Mouth

Do not clean the teeth next to the healing tooth socket for the rest of the day. You should, however, brush and floss your other teeth thoroughly. The tongue should also be brushed. This will help eliminate the bad breath and unpleasant taste that is common after an extraction.

The day after the extraction, *gently* rinse your mouth with warm salt water (half a teaspoon salt in an 8 oz. glass of warm water). Rinsing after meals is important to keep food particles out of the extraction site, but remember not to rinse your mouth vigorously. Avoid using a mouthrinse or mouthwash during this early healing period unless your dentist advises you to do so.

When choosing oral hygiene products, look for those that carry the American Dental Association's Seal of Acceptance—a sign that a product has met ADA criteria for safety and effectiveness.

Follow-Up

If you have sutures that require removal, your dentist will instruct you when to return to the office.

CONSENT FOR ORAL SURGERY

Patient name _____ I hereby authorize

Doctor name _____ and any associates

to perform the following procedure: _____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
2. Postoperative infection requiring additional treatment.
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. In rare circumstances, cardiac arrest or breakage of the jaw.
7. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
8. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
9. Stretching of the corners of the mouth with resultant cracking and bruising.
10. Antibiotics will interfere with birth control. Use an alternate form of birth control or abstain

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgement, they are necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

Please don't hesitate to ask the doctor or staff if you have any questions.

Patient, parent or guardian _____

Doctor _____ Date _____

CONSENT FOR RELEASE OF DENTAL RECORDS

I _____ do hereby consent to and authorize Dr _____ to disclose to _____ (Address) _____ information in my dental records, including current and previous dental records from other practices and practitioners, hospitals, and/or clinics which are part of my dental records.

My date of birth is (month/day/year) _____, and my social security number is _____. This information is strictly for purposes of identification.

Signed: _____
(Patient)

_____
(Date)

(If additional consent is necessary from a person authorized to give consent, other than the patient, such as parent, guardian, etc., obtain signature)

Signed: _____

_____
(Relationship to the Patient)

_____
(Date)