COBB FAMILY DENTISTRY

Patient Information

Welcome to our office. Thank you for allowing us the opportunity to serve your dental needs. Your thoroughness in furnishing the following confidential information is greatly appreciated.

Patient's Name_____Preferred Name_____S.S.#_____
Marital Status: S M D W Sex____Birthdate_____Ages of children in household_____
Address_____Apt. #_____How long there?_____
City _____State _____Zip_____Best Phone#(___)_____

If above patient is an adult please complete the following:
Former Address_____How long there?_____
Employer _____Address_____
How long employed there?_____Position_____Work Phone (___)_____Ext._____
Do you have dental insurance there? _____Insurance Co. Name_____
So that we can assist you with filing your claims, please provide us with your dental insurance card and form.

If above patient is a minor please complete the following:
Name of parent or legal guardian _____
Relationship_____Birthdate_____S.S.#_____
Address_____Apt. #_____How long there?_____
City _____State _____Zip_____Home Phone (___)_____
Employer_____Address_____
How long employed there?_____Position_____Work Phone (___)_____Ext._____
Does this person have dental insurance that covers the patient?_____Insurance Co. Name_____
So that we can assist you with filing your claims, please provide us with your dental insurance card and form.

Name of spouse or second parent or guardian_____
Relationship_____Birthdate_____S.S.#_____
Address_____Apt. #_____How long there?_____
City _____State _____Zip_____Home Phone (___)_____
Employer_____Address_____
How long employed there?_____Position_____Work Phone (___)_____Ext._____
Does this person have dental insurance that covers the patient?_____Insurance Co. Name_____
So that we can assist you with filing your claims, please provide us with your dental insurance card and form.

Nearest relative not living with patient_____Relationship_____Phone (___)_____
Address_____

Method of payment: Cash____Check____Charge Card____Do you want to apply for credit in our office?_____

We appreciate the confidence our patients have in us and would like to know whom we may thank for referring you to our office or how you heard about our office?_____

Please see second page.

PATIENT'S MEDICAL AND DENTAL HISTORY

Patient Name_____

Primary Care Doctor's Name_____ Phone _____

Date of last Physical Exam_____

Are you presently under the care of a physician?_____If yes, why?_____

Have you ever had any joint replacements? _____

Have you ever been advised to take an antibiotic pre-med prior to dental appointments?_____

If patient is a female, is she pregnant now?_____On Birth Control pills?_____Name and Ph# of OB_____

Please mark any of the following the patient has or has ever had a problem with: Date_____BP_____

___Rheumatic Fever	___Diabetes	___Blood Problems	___Sinus Problems
___Heart Condition	___Kidney	___Cerebral Palsy	___Speech or Hearing
___High/Low Blood Pressure	___Lung	___Epilepsy or Seizures	___Anemia
___Hepatitis or Jaundice	___Liver	___Depression/Anxiety	___Asthma
___Bleeding Disorder	___Tuberculosis	___Dementia/Alzheimers	___COPD,Emphysema
___Stroke	___Stomach Ulcers	___Recurrent Headaches	___A.I.D.S./H.I.V.
___Herpes	___Cancer	___Back Problems	___HPV
___Thyroid	___Cholesterol	___Joint Problems	___Other
___Arthritis	___Immune Disorder		

Is patient taking any medications?_____**Please list all medications**:_____

_____

Please mark any of the following that the patient is allergic to:

Penicillin ___ Aspirin ___ Codeine ___ Local Anesthetic ___ Metals ___ Latex ___ No Known Allergies ____

Other _____

Former Dentist's Name_____Address_____

Phone (___)_____Date of last visit in that office_____Date of last full mouth x-rays_____

Reason for present dental visit:_____

Please mark if patient has any of the following:

_____Sensitive teeth	_____Loose teeth	_____Unsatisfied with appearance of teeth
_____Gums that bleed or hurt	_____Grind or clench teeth	_____Existing Full or Partial Dentures
_____Pain or swelling in mouth	_____Clicking sounds when opening	_____Wear Contact Lenses

Do you use any tobacco products?_____ How much?_____

Do you want to save your teeth for a lifetime?_____

Have you ever had a "deep" cleaning?_____

Do you have any concerns about dental treatment?_____

Is there any information you would like us to know that may better help us to serve your dental needs?_____

_____

Signature _____Date_____Relationship to patient_____

(For Office Use Only)

Date	**UPDATES/CHANGES:** (Patient Information, Blood Pressure, Health, Medications, Allergies)	**Initials**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please see third page

FINANCIAL AND APPOINTMENT GUIDELINES

For your convenience, we gladly file dental insurance forms. We will allow you to assign payment to our office so that you will not have to wait for the payment, provided we receive your dental insurance card and forms. We can allow up to 60 days for your insurance company to send us payment. If for any reason your insurance does not pay within 60 days, you will then need to pay us the insurance portion and have the insurance reimburse you. Most insurance companies will pay within this period, but we want you to know that the responsibility for payment rests on the patient or person responsible for the account, regardless of the insurance coverage.

You will be kept informed as to what treatment is needed and what it will cost. All fees are due at the time treatment is performed unless other arrangements have been approved in advance. Any overdue payments will bear a late charge of 1 ½ % per month (18% per year) from the date the fees are charged until they are paid. There is a $25.00 charge for any returned check. If for any reason the account is turned over to an outside collection agency, the additional charge for the fee of the collection agency along with any attorney fees will be applied to your account.

As a service to our patients, we confirm all appointments unless requested otherwise. To make this process as efficient as possible, we ask your help by completing the following.

WE CONFIRM ALL SCHEDULED APPOINTMENTS VIA THE FOLLOWING:

Phone:(____)_____ Email:_____

Text: (____) _____ Other (____)_____

In the best interest of your dental health, we ask that you make every effort to keep all reserved appointments. If this is not possible, we ask that you give us at least a full working day (24 hrs from appt) notice so that another patient waiting for dental treatment or in need of immediate attention may be brought in at the time that was reserved for you. If insufficient notice is given, we reserve the right to charge ($50) for that missed appointment time.

The undersigned has read and understands the above and hereby authorizes the Doctor to perform treatment that is deemed necessary in the best interest of the patient's health.

Signature _____Date_____Relationship to patient_____
(Adult patient, parent, or guardian)