HEALTH, HISTORY & REGISTRATION

Today's Date _____

Name _____ Sex: M F Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation _____ Home Phone Number _____

Your Employer _____ How Long Employed? _____ Social Security # _____ Work Phone Number _____

If not employed, are you a full time student? ☐ Yes ☐ No School Name _____ Cell Phone Number _____

Name of Spouse (Parent if Minor) _____ Person Responsible for Account _____

Spouse's Employer _____ Spouse's Social Security # _____ Work Phone Number _____

Referred to us by _____ Spouse's Date of Birth _____ Reason for Visit _____

Name and Phone # of Medical Doctor _____

Nearest relative not living with you _____
Name Address Phone #

INSURANCE INFORMATION

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
_____
Insured's Employer _____
Insured's Social Security # _____
Group # _____ Local # _____

If you have double insurance coverage complete this for the second coverage
Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
_____
Insured's Employer _____
Insured's Social Security # _____
Group # _____ Local # _____

If patient has insurance coverage, it is understood that any fee not covered by their insurance company is the responsibility of the patient. Payment is expected for service rendered at time of the first visit.

Would you like to receive appointment reminders by:

Text Messaging Yes ____ No ____ #_____

Email: Yes ____ No ____ Email Address _____

May we contact you by telephone to schedule an appointment weekdays from 6 – 8 pm? Yes _____ No_____

IF MEDICAL INFORMATION IS CORRECT PLEASE DATE AND SIGN BELOW.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

YES Do you have any CURRENT HEALTH PROBLEMS NO
If you are under a PHYSICIAN'S CARE please list on back
YES Are you HIV Positive? NO
YES Any type of HEART PROBLEMS? BYPASS? PACEMAKER? NO
YES High Blood Pressure? NO
YES Diabetes? NO
YES Fainting Spells, Seizures, or Epilepsy? NO
YES ULCERS, or Stomach Problems? NO
YES Nervous Problems? NO
YES Asthma, or any Respiratory Problems? NO
YES Hepatitis, or any Liver Damage or Anemia? NO
YES Surgery or Radiation for any Growths or Tumors? NO
YES Rheumatic Fever? NO
YES Does your Medical Doctor require you to take an ANTIBIOTICS before having any Dental Procedures? NO
YES Are you PREGNANT? NO
YES Do you use TOBACCO? (Cigarettes, Pipe, Chewing) NO
YES Are you taking any MEDICATIONS now? NO
PLEASE LIST THEM ON BACK
YES Are you ALLERGIC to PENICILLIN? NO
YES Are you ALLERGIC to CODIENE? NO
YES Any OTHER DRUG ALLERGIES? To What? NO
PLEASE LIST THEM ON BACK
YES ANY OTHER MEDICAL CONDITIONS? NO
PLEASE LIST THEM ON BACK
YES Are you ALLERGIC to LOCAL ANESTHETIC? NO
YES Are you taking a blood thinner or aspirin or have have abnormal bleeding? NO

I hereby authorize Dr. Stoddard to perform any and all treatment for the above patient.

Patient's Signature _____
(Parent/Guardian, if Minor)

Date _____

UNDER PHYSICIANS CARE FOR:

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ANY OTHER ALLERGIES YOU HAVE:

_____	_____
_____	_____
_____	_____

OTHER MEDICAL CONDITIONS YOU HAVE:

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Cox Creek Family Dentistry

Address: 721 Cox Creek Parkway

City/State/Zip: Florence, AL 35630

DENTAL TREATMENT CONSENT AND INFORMATION FORM

I understand certain risks are associated with all dental treatments. Complications may result from the use of dental instruments, drugs, and anesthetics. These may include, but are not limited to, swelling, sensitivity, bleeding, pain, infection, and numbness which usually lasts for a few hours but may be permanent, reaction to shots, changes in biting and the way the teeth fit together, muscle cramps, joint difficulties, loosening of teeth, damages to other teeth, pain to the ear, neck, and head, nausea, vomiting, other allergic reactions, delayed healing, sinus perforations, broken roots, broken instruments and treatment failure.

I understand that I may have to take certain medication (drugs) while dental treatment is being performed which may result in allergic reactions, drowsiness, or lack of awareness and coordination. I understand that I am not to use alcohol, tranquilizers, or sedatives while on medication for my treatment unless otherwise instructed by my doctor. I understand that I am not to drive or operate a car or other machines while taking certain medication as indicated by my doctor.

I understand that risks associated with no treatment include, but are not limited to pain, infection, swelling, loss of teeth and bone, and/or infection to other areas of the body.

I understand that upon completion of my dental treatment regular cleaning and/or dental checkups are advised.

Any and all of my questions have been clearly answered. I also understand that any questions that I might have during my treatment will be answered when I ask them. I, the undersigned, being the patient (parent or guardian of a minor patient) consent to dental treatment on the involved tooth or teeth and/or gums. I have read this form.

Patient Name _____

Date Signed	Signature of Patient (Parent or Guardian)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

(Patient Name)

FINANCIAL AGREEMENT

Unless other written arrangements are made before treatment, I agree to pay Cox Creek Family Dentistry, P.C. for dental services the day the services are provided. I agree to pay all charges not covered by my insurance or other third parties. I also agree to pay any and all collection fees, attorney fees and court costs in addition to the balance if this account is placed in collection.

_____

Print Name of Responsible Party

_____ _____

Signature of Responsible Party Date

Cancellation and Broken Appointment Policy

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplishing that goal. The appointment you schedule for your treatment is reserved for you and your treatment only. We understand that illness, emergencies, and bad weather do occur. We ask our patients to give us 48 hours notice whenever possible, if they cannot keep an appointment. This allows us to fill our schedule without double booking patients to compensate for missed appointments.

Policy and Fees:

Cancellation or rescheduling of an appointment without giving a 48 hour notice may or may not be considered a broken appointment: it will be at out discretion.

Failure to give 24 hour notice:

- We allow for (1) broken appointment within a 12 month period
- Any additional broken appointment within a 12 month period will be charged a fee

  $40 for each hygiene appointment

  $50 for each doctor's appointment

We appreciate your understanding and consideration regarding our appointment policy. If you have any questions or concerns, please never hesitate to ask us at Cox Creek Family Dentistry.

I have read and understand the above mentioned policy.

_____ _____

Patient Signature (Parent or Guardian if minor) Date