COX DENTAL CARE

Patient Information:

First Name: _____ Last Name: _____ M.I. _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Social Security Number: _____ Sex: Male or Female (please circle)

Email: _____

☐ I would like to receive correspondences via e-mail

Marital Status: Married Single Divorced Separated Widowed (please circle)

Referral Source: Mailer Radio Fox 21 Insurance List (please circle) Other: _____

Responsible Party Information (For patients under 18 years of age)

First Name: _____ Last Name: _____ M.I. _____

Birth Date: _____ Social Security Number: _____ Phone: _____

Address: _____

Dental Insurance Information:

Insured's Name: _____ Insured's Social Security # _____

Insurance Co: _____ Group No. _____

Insurance Co. Address: _____

Insurance Co. Phone No. _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name: _____ Insured's Social Security # _____

Insurance Co. Address _____ Phone No. _____

Emergency Information:

Contact Name and relationship to patient:

_____ Phone _____

Signature: _____

Cox Dental Care, PA

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	☐ Yes ☐ No	If yes
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes
Have you taken Fosamax, Boniva or Actonel or any other meds for any bone condition such as	☐ Yes ☐ No	If yes
Are you taking blood thinners, an aspirin regimen or anti-coagulants, such as Plavix, Coumadin, Eliquis,	☐ Yes ☐ No	If yes
Are you on a special diet?	☐ Yes ☐ No	If yes
Do you use tobacco products?	☐ Yes ☐ No	If yes

Women. Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Nitrous Oxide	☐ Tetracycline	☐ Erythromycin	☐ Valium

Other?	☐	If yes
Do you use controlled substances?	☐ Yes ☐ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Knee or Hip ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Yellow Jaundice ☐ Yes ☐ No			

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices
Last Updated: November 2015
Cox Dental Care, PA
206B South Main Street, Greer, SC 29650

I, _____, hereby acknowledge that I have received and reviewed a copy of Cox Dental Care's *HIPAA Notice of Privacy Practices.*

I understand that Cox Dental Care's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Cox Dental Care's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Cox Dental Care's *HIPAA Notice of Privacy Practices*, I may contact Office of Consumer Services at any time by calling 803-737-6180.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Cox Dental Care will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Cox Dental Care's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask contact Office of Consumer Services, noted above, for assistance.

_____ _____

Patient Signature Date

_____

Print Name

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child (ren) _____
- ☐ Other _____
- ☐ Information not to be released to anyone.

Financial Policy Acknowledgment:

The following information is to inform you of our financial policy. If, at any time, you have questions regarding this policy, please do not hesitate to ask any member of our staff. We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, Mastercard, American Express, or Discover Cards. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options.

No personal checks accepted unless approved by management. A $30 fee will be added to the full amount of any bounced check.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. **Payment is expected at the time of treatment.** A delinquent account impedes our ability to provide you with the quality dental care that you deserve. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, **any appointment missed may be subject to a missed appointment fee of $25 (for canceling between 24 and 48 hours before appointment) or $50 (for canceling less than 24 hours before appointment),** which will be an out-of-pocket expense and will not be filed to your insurance. Should you find it necessary to reschedule an appointment, please provide us with a notice of two business days to avoid being charged a missed appointment fee.

Important Facts About Your Dental Insurance:

As a **courtesy** to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense. Please contact your insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims. If you have a direct reimbursement policy, payment in full is expected on the day of service and your dental plan will reimburse you.

Dental Insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment. If we do not receive payment from your insurance carrier within **60 days** of date of services rendered, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Treatment plans reflect estimated fees and insurance coverage. Although we make every attempt to gather your insurance benefits, it is ultimately **your responsibility** to know your plan's coverage.

At any time for any reason that your insurance does NOT pay for services already rendered, you are responsible for those services at our **standard rate**. At that time, a late fee of $15 will be added per month that the balance isn't paid.

Patient/Parent/Guardian Signature: _____ Date: _____