WELCOME TO OUR OFFICE

HOWDY JONES & COCHRAN

Dr. Mrs. Ms. Mr. Male/Female

Today's Date _____

Name _____ S.S.# _____ Date of Birth _____
Last First M.I.

Address _____ Marital Status _____ Age _____

City _____ State _____ Zip _____ Home Phone _____

Place of Employment _____ Office Phone _____

Person responsible for payment of account _____ Cell Phone # _____

E-mail Address _____ Spouse Cell # _____

Full Name of Spouse/Parent _____ Spouse's Occupation _____

In Case of Emergency Notify _____ Phone _____

Physician's Name _____ Physician's Phone _____

PLEASE PROVIDE CURRENT MEDICATIONS (PRESCRIPTIONS) _____

Are you ALLERGIC to latex, metals, Sulfa drugs, Antibiotics, or any other medications/materials? _____

Are you under a doctors care now? ☐ YES ☐ NO, if yes explain. _____

PATIENT MEDICAL HISTORY - CHECK YES OR NO

Do you have/use or have you had/used any of the following?

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

☐ YES ☐ NO Have you taken Fosamax, Boniva, Actonel, or any others for Osteoporosis? _____

☐ YES ☐ NO Have you taken Phen-Fen or Redux?

☐ YES ☐ NO Have you ever been hospitalized or had a major operation? _____

_____

PATIENT DENTAL HISTORY

☐ YES ☐ NO Have you had regular dental check-ups in the past?

How often? _____

When was your last full mouth X-ray taken? _____

Where? _____

☐ YES ☐ NO Do you habitually clench or grind teeth, day or night?

☐ YES ☐ NO Have you had any prolonged bleeding after extractions?

☐ YES ☐ NO Do your gums bleed?

☐ YES ☐ NO Any history of orthodontics - braces?

IF PATIENT HERE FOR DENTURES, PLEASE ANSWER

☐ YES ☐ NO Have you had previous dentures?

Upper/Lower? _____

When was your last set made? _____

When were your teeth removed/extracted? _____

I authorize the following people to access my information, including financial billing & dental treatment:

Name _____

Relationship to Patient _____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ Date _____

– OVER –

NOTICE OF HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT

Signature _____ Relationship to Patient _____

PATIENTS WITHOUT INSURANCE

Full payment is due at the time of service. A 1.5% interest fee will be applied monthly to accounts unpaid.

PATIENTS WITH INSURANCE

We file claims to your primary insurance carrier if all the necessary information is made available. As a service to you, our office estimates the financial portion your insurance company could pay for your dental treatment. We expect your estimated financial portion to be paid at the time dental treatment is rendered. You are ultimately responsible for any unpaid balance. For unpaid accounts, a 1.5% interest fee will be applied monthly.

Dental Insurance Company _____ Policy #: _____

Policy Holder _____

Name Address DOB SS#

Policy Holder Employer _____ Relationship to Patient _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to Howdy Jones Cochran, PA for dental services rendered. I further authorize the release of any medical information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment. I realize that an account over 3 months old may be turned over to a third party collection agency.

Signature _____ Date _____

Relationship to patient _____ Phone # _____

ANNUAL MEDICAL HISTORY RECERTIFICATION

I certify that there have been no changes in my health except as noted below:

DATE	CHANGE	SIGNATURE