Welcome to Cottingham Family Dentistry

Patient's Name: _____ Today's Date:_____

_____

Address: _____

_____

_____

Phone (home):_____ Phone(work):_____

_____

Phone (cell):_____ Email Address: _____

May we email or text information or reminders to you? _____

Date Of Birth: _____ Gender: _____ Marital Status:_____

HEALTHINFORMATION (Yes or No)

_____ Anemia

_____Diabetes

_____Hepatts

_____ AIDS/HIV

_____High Blood Pressure

_____Allergies

_____Loss of Bone Density

_____Abnormal Heart Condition

_____Excessive Bleeding

_____ Rheumatic Fever

_____ Joint Valve Replacement

_____ Low Blood Pressure

_____ Heart Murmur

If you answered yes to any of the above, please provide any needed explanation: _____

_____

_____

Are you allergic to any medication and/or latex? Which medications? _____

_____

_____

Are you taking aspirin or any other blood thinner on a regular basis? _____

_____

Have you ever had any complications following dental treatment? _____ *Please explain:*

_____

_____

_____

If there any medical information not listed that we need to know? _____

_____

_____

Are you under the care of a physician? _____*If yes, please explain.* _____

_____

_____

EMPLOYMENT INFORMATION

Complete the following info for the person responsible for payment.

Employer Name: _____ ***Occupation:*** _____

Phone #: _____

INSURANCE INFORMATION

Insurance Co. Name _____

Insurance Co. Address _____

Name of Insured: _____ *Is insured the patient?* _____

Insured's Date of Birth: _____ *ID#* _____ *Group#* _____

Insured's Employer's Name: _____

Insured's Relationship to Patient:_____ Insured's Phone:_____

Secondary Dental Insurance

Insurance Co. Name_____

Insurance Co. Address_____

Name of Insured:_____ Is insured the patient?_____

Insured's Date of Birth:_____ ID# _____ Group#_____

Insured's Employer's Name:_____

Insured's Relationship to Patient:_____ Insured's Phone:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Patient_____ Relative_____
Friend_____ Dental Office___ Yellow Pages_____ Internet_____

Name of Person referring you to our practice_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility for each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I hereby authorize payment directly to the dentist of the below-named of the group insurance benefits otherwise payable to me. I have read the above conditions of treatment and agree to consent.

Signature of patient, parent, or guardian_____
Date _____