Cotton Creek
DENTAL

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Preferred Name:_____ Gender: M / F Date of Birth:_____

SSN:_____ Married: Y / N

Address:_____City:_____State:____ Zip:_____

Email:_____Home Phone:_____Cell:_____

Employer Name:_____ Employer Phone:_____

Emergency Contact:_____ Emergency Phone:_____

How did you hear about Cotton Creek Dental?:_____

RESPONSIBLE PARTY

If the patient is under 18 years old, please complete the following:

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Gender: M / F SSN:_____ Married: Y / N

Email:_____Home Phone:_____Cell:_____

INSURANCE POLICY

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name:_____ Subscriber DOB #:_____ Subscriber SSN:_____

Insurance Company Name:_____ Insurance Company Phone:_____

ID Member #:_____ Group #:_____ Employer/Group Name:_____

DENTAL HEALTH

Reason for today's visit:_____ Date of last dental visit:_____

Are you in pain? Y / N Do your gums bleed? Y / N Do you have your wisdom teeth? Y / N

Unusual reaction to dental injections?_____

How happy are you with your smile? Choose 1-10: Not Happy 1 2 3 4 5 6 7 8 9 10 Very Happy

Are you interested in our sedation or comfort options? Laughing gas / Oral Sedation / IV / Other / None

What can we do to make your visits more comfortable? _____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State:_____

List any medications you are now taking:

[ ] None

_____

_____

_____

_____

_____

Check any you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/Other Narcotics
[ ] Erythromycin
[ ] Latex
[ ] Anesthetics/EPI
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Seasonal
[ ] Other:_____

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Alzheimers
[ ] Anemia
[ ] Angina
[ ] Anorexia/Bulimia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Bladder Trouble
[ ] Blood Clotting Issues
[ ] Cancer
[ ] Chest Pain upon Exertion
[ ] Damaged Heart Valve
[ ] Depression
[ ] Diabetes
[ ] Dizziness
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells
[ ] Fever Blisters
[ ] Frequent Dry Mouth
[ ] Frequent Headaches
[ ] Head Injuries
[ ] Heart Attack
[ ] Heart Disease
[ ] Heart Murmur
[ ] Heart Surgery
[ ] Hepatitis: A / B / C
[ ] High Blood Pressure
[ ] Joint Replacement
[ ] Kidney Disease
[ ] Leukemia
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Concerns
[ ] Pacemaker
[ ] Pulmonary Embolism
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Seizures
[ ] Sinus Problems
[ ] Sleep Apnea/CPAP
[ ] STD
[ ] Stomach Problems
[ ] Stroke
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Tumor
[ ] Ulcers
[ ] Other:
_____

Have you ever been told to premedicate before a dental appointment? Y / N If so, for what?_____

Are you taking, or have you taken, bisphosphonates for osteoporosis? Y / N / Not sure
If yes, circle one: Fosamax / Actonel / Boniva / Reclast / Prolia / Evista / Duavee / Other: _____

Tobacco use? Y / N If so, what kind and how often?_____
Vaping/Ecig use? Y / N If so, what kind and how often?_____

Women: Are you pregnant? Y / N Are you taking birth control pills? Y / N

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance and receive payment directly from them. If sent to collections, I agree to pay all related fees and court costs. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

I will be responsible for paying half of the expected cost at the time of scheduling unless another payment arrangement has been made. I understand that all remaining fees are payable at the time of treatment. I understand that the fee listed for dental care can only be extended for a period of up to 90 DAYS from the date of the patient examination. Treatment plans may change during treatment and I will be ultimately responsible for the work that is actually done.

Initials _____

CANCELLATION, MISSED, OR LATE APPOINTMENT POLICY

I understand there is a $50 missed appointment fee, per hour, if I do not notify the office within 24 hours of my appointment time. I also understand that if I am more than 10 minutes late for my scheduled appointment I may be asked to reschedule.

Initials_____

HIPAA PRIVACY PRACTICE

I have received and reviewed a copy of this office's Notice Privacy Practices. I have been given the opportunity to have any questions regarding HIPAA policies addressed and certify that all of the above patient information given is true to the best of my knowledge.

Initials _____ Any restrictions Noted:_____

By signing below, I certify that all of the above information is true and correct to the best of my knowledge. I have been given the opportunity to review the information and ask any questions.

Print patient name: _____ Signature:_____

Relationship to patient: Self / Parent / Legal Guardian / Spouse / Caretaker

Date:_____