MARK COX, D.M.D.
ORAL AND MAXILLOFACIAL SURGERY

CONFIDENTIAL REGISTRATION AND MEDICAL HISTORY

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Sex ___ M ___ F Age _____ Date of Birth _____ SS# _____ Marital Status _____

Student? ___ Yes ___ No Name of School _____ City _____ State _____

Home Phone _____ Work Phone _____ Emergency Phone _____

Name of Dentist _____ Orthodontist _____ Physician _____

If patient is a minor, with whom does he/she live? Mother ____ Father _____ Other _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Responsible party name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip_____

Phone _____ Date of Birth _____ SSN# _____

INSURANCE INFORMATION

Insurance Company _____ Medical _____ Dental _____

Insurance Company Address _____

Group # _____ Plan # _____ Phone # _____ ext. _____

Insured's Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

SS# _____ Date of Birth _____ Work Phone _____

Employer _____ Employer Address _____

Secondary Insurance Carrier Name _____ Medical _____ Dental _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ Relationship to Patient _____

SSN _____ Date of Birth _____ Phone # _____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, have insurance with _____ and assign directly to Dr. Cox all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you now under a physician's care or have you been during the past 5 years, including hospitalization(s) and surgery? ..... Y ..... N
2. Have you had any other serious illnesses, operations or hospitalizations? ..... Y ..... N

   If So, Please Describe: _____

   _____

   _____
3. Date of last physical exam _____

   Height _____ Weight _____
4. **Do You Have Or Have You Ever Had:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y ..... N
   - B. Congenital Heart Disease? ..... Y ..... N
   - C. Cardiovascular Disease (Heart Trouble, Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y ..... N
   - D. Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorders? ..... Y ..... N
   - E. Do you snore or have sleep apnea? ..... Y ..... N
   - F. Are you subject to fainting, dizziness, nervous disorders, seizures or epilepsy? ..... Y ..... N
   - G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Do You Bruise Easily? ..... Y ..... N
   - H. Liver Disease (Jaundice, Hepatitis)? ..... Y ..... N
   - I. Kidney Disease? ..... Y ..... N
   - J. Diabetes? ..... Y ..... N
   - K. Thyroid Disease (Goiter)? ..... Y ..... N
   - L. Arthritis? ..... Y ..... N
   - M. Stomach Ulcers or Colitis? ..... Y ..... N
   - N. Glaucoma? ..... Y ..... N
   - O. Frequent Or Recurring Mouth Sores? ..... Y ..... N
   - P. Implants Placed Anywhere In Your Body (Heart Valve, Hip, Knee)? ..... Y ..... N
   - Q. Radiation (X-Ray) Treatment for Cancer? ..... Y ..... N
   - R. Clicking or Popping of Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth? ..... Y ..... N
   - S. Sinus or Nasal Problems? ..... Y ..... N
   - T. Any Operation That Has Depressed your Immune System? ..... Y ..... N
5. **Are You Using Any Of The Following?**
   - A. Antibiotics ..... Y ..... N
   - B. Anticoagulants (Blood Thinners) ..... Y ..... N
   - C. Aspirin or drugs such as Motrin, Aleve Or Ibuprofen ..... Y ..... N
   - D. High Blood Pressure medications ..... Y ..... N
   - E. Steroids (Cortisone, Prednisone, etc) ..... Y ..... N
   - F. Tranquilizers (Valium, Etc.) ..... Y ..... N
   - G. Insulin or Other Anti-Diabetic drugs ..... Y ..... N
   - H. Digitalis, Inderal, Nitroglycerin or any heart drugs .... Y ... . N
   - I. Are you taking or have you ever taken Bisphosphonates like Fosamax, Actonel, Boniva, Zometa, Aredia, Re-Clast for osteoporosis or chemotherapy? ..... Y ..... N
   - J. Please list any and all medications taken, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins, minerals, diet pills such as Re-dux, Phen-Fen or others; _____

     _____

     _____
6. **Are You Allergic To Or Had An Adverse Reaction To:**
   - A. Local Anesthetic (Novacaine, Etc.)? ..... Y ..... N
   - B. Penicillin or other Antibiotics? ..... Y ..... N
   - C. Sedatives, Barbiturates, Etc.? ..... Y ..... N
   - D. Aspirin or Ibuprofen? ..... Y ..... N
   - E. Codeine or Other Pain Killers? ..... Y ..... N
   - F. Latex or Rubber Products? ..... Y ..... N
   - G. Eggs / Yolks? ..... Y ..... N
   - H. Other Allergies or Reactions? If Yes, Please List: _____

     _____

     _____
7. Do You Smoke Or Chew Tobacco? ..... Y ..... N

   How much per day? _____
8. Do you currently use or have a history of using Recreational Drugs? ..... Y ..... N
9. Is there a past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y ..... N
10. Have You Had Any serious problems associated with any Previous Dental Treatment? ..... Y ..... N
11. Have you or an immediate family member had any problems associated with Intravenous Anesthesia? ..... Y ..... N
12. Do You Have Any Other Disease, Condition Or Problem Not Listed Above That You Think the Doctor Should Know About? ..... Y ..... N
13. Do You Wish To Talk With The Doctor Privately? ..... Y ..... N
14. **For Women Only**
    - A. Are you Pregnant, **or is there any chance** you might be Pregnant? ..... Y ..... N
    - B. Are you nursing? ..... Y ..... N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use alternate forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist Dr. Cox in providing the best care possible and I will not hold my care providers responsible for any errors or omissions that I may have made. I have had the opportunity to discuss my Health History with Dr. Cox. I certify that I have read and understand the above.

Date	Signature of Person Completing Health History	Dr. Cox's Initials