DENTAL HISTORY

How long has it been since your last dental visit? _____

Do you experience anxiety when visiting the dentist? _____

How do you feel about your teeth? _____

If you could change one thing about your teeth, what would it be? _____

Would you like to know more about cosmetic dentistry? _____

Do you experience any pain when opening your mouth or chewing? _____

The medical and dental history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____ Signature_____

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to
Name of Insurance Company(ies)
Dr. Cox all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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 _____

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date_____ Signature _____

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. Dr. Cox cannot render services on the assumption that our charges will be paid by the insurance company.
Date_____ Signature _____