Cox Family & Cosmetic Dentistry

JAMES E. COX, D.M.D., P.C. ADAM Z. COX, D.M.D.

Dear Patient,

Our dental team is happy to welcome you to our practice. We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with high quality dental care in a caring, gentle manner.

On your first visit you can expect:

- **an introduction to our office and staff**
- **a thorough examination and assessment of your oral health, including necessary x-rays**
- **a careful evaluation of your dental status**
- **a discussion of the most satisfactory treatment plan to meet your oral health goals**

Enclosed is our office questionnaire. Please complete it at your convenience and bring it with you to your first visit. If you have dental insurance please bring your insurance card with you as well. If your insurance is new and you have not yet received a card, please bring the policy number (sometimes referred to as Subscriber ID), name of insurance company, and a telephone number for your insurance company

We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you.

We look forward to seeing you.

Cordially

Cox Family & Cosmetic Dentistry

914 HIGHWAY 78 EAST • JASPER, ALABAMA 35501
OFFICE 205.384.4000 • FAX 205.302.6487

COX FAMILY & COSMETIC DENTISTRY
914 Highway 78 East
Jasper AL 35501

(205)384-4000
info@coxdental.com
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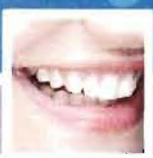

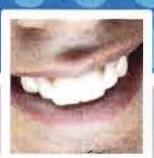

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Spouse or Parent name and phone numbers:

Employer Name:

Please list person responsible for account and his/her phone numbers:

Whom may we thank for referring you to our practice?

Please provide an emergency contact person and his/her phone number, who has your permission to discuss your medical/dental conditions and make decisions on your behalf in the event of an emergency.

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Medical History

Please list your physician and phone number:

Please list any medications you are taking:

☐ *MVP	☐ Acid Reflux	☐ Allergies-other	☐ Allergy - Latex
☐ Allergy - Lortab	☐ Allergy - Penicillin	☐ Allergy-Anesthetics	☐ Allergy-metals
☐ Alzheimers-Dementia	☐ Anemia	☐ Asthma	☐ Bisphosphonates
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Chemotherapy
☐ Cong. Heart Defect	☐ Diabetes	☐ Endocarditis	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting	☐ Head Injury	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Heart Stents	☐ Hepatitis
☐ High Blood Pressure	☐ HIV/AIDS	☐ Joint Replacement	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders	☐ Pacemaker
☐ Prosth. Heart Valve	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatism/Arthritis
☐ Sinus/Allergies	☐ Skin Cancer	☐ Stroke	☐ Thyroid Problems
☐ TMJ Problems	☐ Tuberculosis	☐ Ulcers	

Please list any other allergies not listed:

Please list any other medical conditions not listed:

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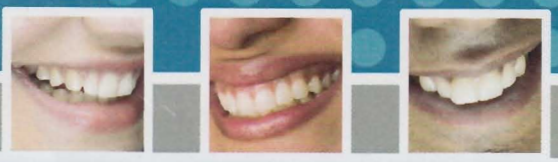

Do you or have you ever taken Zometa, Aredia, Boniva, Reclast, Actonel, or Fosamax?

◯ Yes ◯ No

Do you smoke or use any form of tobacco? If so how much?

Ladies: Are you pregnant, or do you think you may be pregnant? If yes, when is your due date?

Dental History

When was your last dental cleaning, exam, and x-rays? Who was the providing dentist?

Any present dental complaints? Is there anything about your smile that concerns you?

Signature:

Relationship to Patient:

Response Date: