J. Cole White, DDS, PA

2868 W. Martin Luther King Blvd • Fayetteville, AR 72704 • 479-249-8181

WELCOME TO OUR PRACTICE

Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Pref. Name _____

Sex: ☐ Male ☐ Female Birth Date _____ Age _____ Soc. Sec. # _____

Home Phone # (_____) _____ Cell Phone # (_____) _____ E-mail _____

Street _____ Apt. # _____ City _____ State _____ Zip _____

Employer _____ Bus. Phone # (_____) _____

In case of emergency, contact: _____ Phone # (_____) _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____ Spouse's name _____

Whom may we thank for referring you? _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT (IF OTHER THAN YOURSELF)?

☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ Soc. Sec. # _____ Birth Date _____ Age _____ Phone # (_____) _____

Street _____ Apt # _____ City _____ State _____ Zip _____

Employer _____ Bus. Phone # (_____) _____

Fees and Payments

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure will be given to you upon request. If you have any dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X _____ Date: X _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X _____ Date: X _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I authorize the following person(s) to have access to my information covered under the Privacy Practice regarding myself:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Patient Name _____ Birthdate _____
Last First Initial

HEALTH HISTORY

To our patients: Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Medical Doctor: _____

	Yes	No
1. Have there been any changes in your general health in the past year?	☐	☐
2. Are you under the care of a physician? _____ Date of last visit: _____	☐	☐
If so, for what are you being treated?		
3. Have you had any illness, operation, or been hospitalized in the past five years?	☐	☐
If so, describe		
4. Do you have unhealed injuries or inflamed areas, growth or sore spots in or around your mouth?	☐	☐
If so, describe where		
5. Do you have a prosthetic joint/implant?	☐	☐
6. Have you had a heart valve replacement or vascular graft?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...		Yes	No
7	Rheumatic fever		
8	Damaged heart valves/mitral valve prolapse		
9	Heart murmur		
10	High blood pressure		
11	Low blood pressure		
12	Chest pain / angina		
13	Heart attack(s)		
14	Irregular heart beat		
15	Cardiac pacemaker		
16	Heart surgery		
17	Bronchitis, chronic cough		
18	Asthma		
19	Snoring / sleep apnea		
20	Difficulty breathing / other lung trouble		
21	Tuberculosis		
22	Emphysema		
23	Do you smoke?		
24	Do you use chewing tobacco?		
25	Blood disorder such as anemia		
26	Bruise easily		
27	Bleeding tendency / abnormal bleeding		
28	Hepatitis, jaundice or liver disease		
29	Fainting spells		
30	Convulsions / epilepsy		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...		Yes	No
31	Stroke		
32	Thyroid trouble		
33	Diabetes		
34	Low blood sugar		
35	Kidney trouble		
36	Are you on dialysis?		
37	Swollen ankles, arthritis or joint disease		
38	Contagious diseases		
39	HIV / AIDS		
40	Sexually transmitted disease		
41	Problems with the immune system		
42	Delay in healing		
43	A tumor or growth		
44	Radiation therapy / chemotherapy		
45	Chronic fatigue / night sweats		
46	A history of drug abuse		
47	A history of alcohol abuse		
48	Eye diseases / glaucoma		
49	Mental health problems		
50	Pain and clicking of jaws when eating		
51	Malignant hyperthermia		
52	Do you have hereditary Angioedema?		
53	Do you have unusual facial swelling following a dental procedure that is unrelated to an infection?		

MEDICATION ARE YOU NOW TAKING...		Yes	No
54	Any kind of medication, drugs, or pills?		
55	Blood thinners		
56	Any natural product, herbal supplement or homeopathic remedy?		

Please list ALL medications and over the counter drugs and supplements you are currently taking.

ALLERGIES ARE YOU ALLERGIC TO OR HAD A REACTION TO...		Yes	No
57	Local anesthetic (numbing med.)		
58	Penicillin		
59	Other antibiotics:		
60	Benzocaine		
61	Aspirin		
62	Codeine or other narcotics:		
63	Other medications:		
64	Latex		
65	Please list any allergies other than drug allergies:		

WOMEN ONLY #66-69		Yes	No
66	Is there a possibility of pregnancy?		
67	Expected delivery date_____		
68	Are you nursing?		
69	Are you taking birth control pills?		

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

Is there any condition concerning your health that the Doctor should be told about?

☐ Yes ☐ No *(if so, describe)*_____

Do you take or have you taken: duration?

			Yes	No
Aredia _____	Actonel _____	Didronel _____	☐	☐
Boniva _____	Atelvia _____	Skelid _____	☐	☐
Zometa _____	Fosamax _____		☐	☐
Bonefos _____	Reclast _____		☐	☐

If you had or have cancer, what drugs are you or have you been treated with?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

DENTAL HISTORY

Reason for today's visit: _____

Check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

MHR _____ _____ MHR _____ _____

Date Initial Date Initial

Cole White Dental Cancellation Policy

Here at Cole White Dental, we are committed to supporting our patients and delivering exceptional care. We value and respect our patients. In return, we ask that you please value our doctors and their time, by communicating effectively with our friendly front office team.

Cancellation Policy:

We require a 48 hour business day notice to cancel or reschedule all appointments, to allow the opportunity to schedule other patients. If we do not receive 48 hour business day notice, you will be charged a **$75** fee. This amount must be paid prior to the next appointment for your household.

I,_____, have read and understood Cole White Dental's cancellation policy.
{Please Print Name}

_____
{Signature}

_____
{Date}