CONFIDENTIAL PATIENT INFORMATION
JIM E. COX, DDS
PLEASE PRINT OR WRITE LEGIBLY

Date _____

Patient's

Last Name_____ First Name_____ Middle Int._____
Preferred Name_____ Birthdate _____ Age_____
Address_____
(City) (St.) (Zip)
Home phone_____ How long at this address? _____ Sex: M____ F____
SS #_____-_____-_____ Marital Status: S____ M____ D____ W____ Sep.____
Employer_____ Employer Address_____
Work Phone_____ Ext. _____ How long employed?_____
Occupation_____ Student/School_____
Cell phone _____ Pager _____ Fax _____ E-mail _____
Is another member of your family a patient in our office? _____
How did you find out about our office? _____
Preferred Pharmacy_____ Phone _____

Person Responsible for Paying for Treatment IF DIFFERENT FROM PATIENT:

Relationship to patient:_____ Marital Status: S___M___D___W___Sep.____
Your name:_____ Name of your spouse:_____
Mailing address_____
(City) (St.) (Zip)
Home phone_____ Work phone_____ Ext. _____
SS # _____ Birthdate _____ Sex: M____ F ____
Cell Phone _____ Pager _____ Fax _____ E-mail _____
Employer _____ Employer Address _____
How Long Employed? _____ Spouse's Employer _____
Spouse's Work Phone _____Ext. _____ How long employed? _____

Patient's Spouse or Parent (circle one)

Name _____SS# _____ Date of Birth _____
Spouse or Parent's Employer_____ Work phone_____
Employer's Address _____
(City) (St.) (Zip)
Cell Phone _____ Pager _____ Fax _____ E-mail _____
Occupation _____How long employed _____

In Event of Emergency, (2) people to contact:

1. NAME: (Other than spouse) _____ Phone _____
Address _____
2. NAME: (Other than relative)_____ Phone_____
Address _____

PLEASE READ THE DISCLOSURES BELOW, SIGN AND DATE

INSURANCE: If you wish to have your insurance forms submitted for payment of services, you must understand that co-payment of any deductible will be due at time of service. THERE ARE NO EXCEPTIONS HERE. Furthermore, I understand that any balance remaining after my insurance company has paid on my claim will be due and payable in full by me.

*Signature:*_____ *Date:* ____/____/____

PRE-PAY DISCOUNT: If you wish to pay for an ENTIRE plan of treatment PRIOR to service, you will receive an 8% discount on the entire amount of the treatment. You MUST pre-pay at the time you make your appointment.

*Signature:*_____ *Date:* ____/____/____

LAYAWAY: If you would prefer to make monthly payments but do not want to use any of the options, you may pre-pay for any of our services. After you have paid for all of your estimated charges, treatment can begin. A pre-pay discount of 8% will then apply.

*Signature:*_____ *Date:* ____/____/____

CARE CREDIT: If you would like this method of payment this will allow you to finance your dental work with 18 months no-interest up to 72 months with monthly payments. There are many options with Care Credit so please ask the front desk for further details.

*Signature:*_____ *Date:* ____/____/____

Please sign and date each of the following above indicating that you have read and understand

A late charge of the 1.5% per month, which is an annual percentage rate of 18% will be added to past due accounts over 60 days old. This will include accounts pending insurance.

We **require one working days notice for appointment changes. There will be a $25-$85 charge (depending on amount of time reserved) for cancellations with less than one working days notice. "No-shows" will be billed at 100% of the scheduled treatment. By signing below you acknowledge and understand the financial terms of this office.*

_____ ____/____/____

Signature: *Date*

YOUR HEALTH HISTORY

Patient's Name _____ Date _____

Parent or Guardian's Name, if child _____

Please complete the following confidential information:

Name of Family Physician _____ Phone# _____

Name of Previous Dentist _____ Address _____

Date of last dental cleaning _____

How is your general health? Excellent? Good? Fair? Poor?

Date of last complete physical? _____

Have you been hospitalized and/or had surgery within the past five years? _____

If yes, please explain _____

Are you presently taking any medication? _____ Please list medication & condition: _____

_____

Do you use tobacco products? _____ Pks per day/yr. _____/_____

Women: Are you taking birth control pills? (antibiotics can interfere with birth control pills) _____

Are you pregnant? _____ Delivery date _____ Nursing? _____

Do you have, or have you ever had any of the following? (please circle)

Acid Reflux
AIDS/HIV Positive
Allergies
Angina
Arthritis
Asthma
Blood Disorder
Diabetes
Drug addiction
Eating Disorders
Epilepsy
Excessive bleeding
Excessive daytime sleepiness
Fainting
GERD
Heart attack, when _____
Heart Disease/Problems-type?
_____
Heart Murmur
Hepatitis-type? _____
High/Low Blood Pressure
Hormone Problems
Kidney Disease
Liver Disease
Metal Allergy
Migraines
Mitral Valve Prolapse
Osteoporosis Medications
Panic Disorder
Psychiatric Treatment
Radiation/Chemo
Rheumatic Fever
Sinus Trouble
Sleep Apnea
Snoring
Stroke, when _____
Thyroid Disease
Tuberculosis
Tumor History
Ulcers
Man-made object such as plates, screws, filters, valves, devices or artifical joints in your body? _____

Do you have any disease, condition or problem not listed above? _____

Have you been told that you need an antibiotic before receiving dental treatment? _____

Are you allergic to or have you reacted adversely to any of the following? Penicillin, Local Anesthetic, Aspirin, Codeine, Other antibiotic, Other _____

Consent: I consent to treatment as necessary or desirable for the diagnosis of dental disease or treatment of dental emergency. This may include but not be limited to radiographs (x-rays), models, and intraoral examination. In the case of dental emergency I consent to treatment deemed necessary by the Doctor, understanding that the procedures will be explained in advance. I consent to the use of local anesthetic and/or relaxants for completing necessary treatment. I have read, understand, and agree to the above.

Signed _____ Date _____

Dear Patient,

We understand that choosing a new dentist and dental health team can be a challenge, leaving you feeling somewhat uncertain. Let us welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

"Our purpose is to help people achieve the highest level of well-being appropriate for them, and in so doing, to enhance the quality of their lives."

In other words, we help you be or become as healthy as you choose. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice. Please check the level of care you feel most appropriate for you at this time.

___ Level 1 . . . URGENT CARE
People in crisis or with an emergency problem such as pain, swelling or bleeding that need our immediate help are at this level. We see urgencies immediately, whenever possible.

___ Level 2 . . . REMEDIAL CARE
People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally people at this level expect a limited type of examination, focusing on obvious problems. They usually want to correct immediate problems with as little effort and cost as possible.

___ Level 3 . . . SELF-CARE
Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However; they usually choose repair solutions that are short range in nature.

___ Level 4 . . . COMPLETE DENTISTRY
Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However; they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion as possible.

___ Level 5 . . . LOOK YOUR BEST
People in this group are in level 4 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best foot forward.

We hope these levels make sense to you. It is not uncommon for people to begin at one level and progress to another over time. We are here to help you discover and decide at what level you are most comfortable. Thank you for the opportunity to serve you and provide you with the best dentistry appropriate for you.

PLEASE SELECT ONE

HIPAA Notice Of Privacy Practice

James E. Cox, Jr., DDS
501 S. Main Street
Newcastle, OK 73065

THIS NOTICE DESCRIBES HOW PATIENT INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected patient information (PPI) to carry out treatment, payment or patient care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected patient information. "Protected patient information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related dental care services.

1. Uses and Disclosures of Protected Patient Information

Uses and Disclosures of Protected Health Information
Your protected patient information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for purposes of providing dental services to you, or your child, to pay your dental bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your/your child's protected patient information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, your protected patient information may be provided to an oral surgeon to whom you have been referred to ensure that he would have the necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your dental care services.

Dentalcare Operations: We may use or disclose, as-needed, your protected patient information in order to support the business activities of our dental office. We may call your name in the waiting room when the dentist or hygienist is ready to see you. We may use or disclose your protected patient information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected patient information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of our rights with respect to your protected patient information.

You have the right to request and copy your protected patient information. Under federal law, however, you must not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected patient information that is subject to law that prohibits access to protected patient information.

You have the right to request a restriction of your protected patient information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or dental care operations. You may also request that any part of your protected patient information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restriction requested and to whom you want the restrictions to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected patient information, your protected patient information will not be restricted. You then have the right to use another dental professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected patient information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before July 16, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (405)387-5858.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Patient Name: _____ Patient Signature: _____

Parent/Guardian Signature: _____ Date: _____

JIM E. COX, JR., D.D.S.
501 S. MAIN STREET
NEWCASTLE, OK 73065
(405) 387-5858
FAX (405) 387-2034

FINANCIAL AGREEMENT

All charges for my dental services are due & payable by me at the time of service. Filing a claim for dental services is offered as a courtesy to patients with dental insurance. In that case, any deductible and *estimated* co-pay are due on the date of service. I understand that any balance remaining after my insurance has paid will be due and payable in full by me.

A late charge of 1.5% per month, which is an annual percentage rate of 18% will be added to past due accounts over 60 days old. This will include accounts pending insurance.

We require one working days notice for appointment changes. There will be a $25-$85 charge (depending on the amount of time reserved) for cancellations with less than one working days notice. "No shows" will be billed at 100% of the scheduled treatment.

By signing below you acknowledge and understand the financial terms of this office.

_____ _____

Signature Date