James A. Cox, D.D.S. * Cristian Miranda, D.D.S. * Associates
652 Homer Ave * Palo Alto, CA 94301 (650) 326-7257

Please print the following information & complete both sides, Thank You

Patient_____ Birthday_____
Last Name First Middle (Nick Name) Month / Day / Year
Person Responsible for the bill _____Social Security No._____

Residence Address_____ Phone ( ) _____
(Best # to reach you)
City_____State_____Zip_____Cell Phone ( ) _____
(Best # to reach you)
E-mail address _____ Please Indicate Preferred Contact Method: _____

Business Address _____ Phone ( ) _____

City _____ State _____ Zip_____

Employer _____ Occupation _____

Drivers License _____

Full name of Spouse _____ Contact Number _____

Spouse Employed by _____ Occupation _____

In case of an emergency, closest relative or friend _____
Name Phone #
Referral Source _____

Please give insurance Card to front Desk @ time of check in, Thank you

Dental Insurance Prime Carrier **Ortho Coverage _____**

Dental Insurance Carrier _____ Group # _____

Carrier Address _____Phone Number: _____

Name of Insured _____ Soc.Sec.No._____

Birthday of Insured _____ Employer _____ Relationship to Patient_____

Dental Insurance Second Carrier / Dual **Ortho Coverage _____**

2nd Dental Insurance Carrier _____ Group # _____

Carrier Address _____

Name of Insured _____Soc. Sec No._____

Birthday of Insured _____ Employer_____ Relationship to Patient_____

Please complete other side, Thank you.

Please Answer Each Question

1. Are you in good health? YES / NO
2. Have there been any changes in your health recently? YES / NO
3. Are you now or have you been under the care of a physician or been in a hospital during the last two years? YES / NO
   If so, what was the condition you were treated for? _____
   Please list your general physician incl. phone number _____
4. Do you now or have you taken any kind of medicine or drugs during the past year? YES / NO
   If so, what? _____
5. Please circle if you have taken any of the following osteoporosis supplements:
   Fosamax Actonel Boniva
   If so, please indicated date began: _____
   Any other osteoporosis supplement _____
6. Have you had abnormal bleeding with previous extractions or surgery? YES / NO
7. Are you subject to any nervous disorders, fainting or dizziness? YES / NO
8. Have you ever experienced any ill effect from Latex, Novocain, Penicillin or any other drugs? YES / NO
   If so, please explain: _____
9. Please circle if you have/or have had any of the following:

Heart Trouble	Heart Murmur	Anemia	Tumor or Growth
Rheumatic Fever	Asthma	Diabetes	Pacemaker
Tuberculosis	Hepatitis	Jaundice	Other, Please State:
Arthritis	Stroke	High Blood Pressure	_____

10. Have you had any other serious illnesses not listed above we should know about? YES / NO
    If so, please explain_____
11. Have you experienced any unfavorable reaction or experience from any previous dental treatment? YES / NO
12. Women: Are you pregnant? YES / NO
13. Do you have any present dental complaints? YES / NO
14. Any changes in your insurance coverage? YES / NO
15. Are you required to pre-medicate prior to dental procedures? Reason: _____ YES / NO

Please feel free to discuss any information you do not wish to document here.

- **Please be advised that as a courtesy we will process your insurance claim for you. Patients are responsible for all dental fees at the time of service regardless of insurance coverage.**
- **24-hour cancellation notice is required for all appointments or a service fee will be applied.**
- **Payment Methods Cash / Check / Credit Card/ Care Credit Card**

Consent for Treatment

I do hereby authorize Dr. James Cox, Dr. Cristian Miranda and associates to administer such anesthetics and perform such treatment as may be necessary for the above named patient. I am also aware that the office charges a late fee of 18% for any outstanding balances over 30 days.

Signed_____ **Date**_____

Reviewed by Hygienist _____**Date**_____

Reviewed by Doctor_____**Date**_____