

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“You May refuse to Sign this Acknowledgement”

I, _____, have received a copy of Cooper Family Dentistry’s
Notice of Privacy Practices.

Please Print Name _____

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
But acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An Emergency situation prevented us from obtaining acknowledgement.

_____ Other (Please Specify).

1. I hereby authorize and direct the dentist (s) of Cooper Family Dentistry and / or dental auxiliaries of his / her choice to perform the following dental treatment or oral surgery procedure (s), including the use of any necessary or advisable local anesthesia, radiographs (x-ray), or diagnostic aids.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full crowns).
 - E. Removal (extractions) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and / or soft).
 - G. Treatment of malposed (crooked) teeth and /or oral development or growth abnormalities.
2. I understand that there are risk involved in this treatment and hereby acknowledge that these risks will be explained to me. That I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of a local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risk and complications.
4. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional or different procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting lip and cheek biting resulting in ulcerations and infections of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and the lack of oxygen to the brain that could cause coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, and other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will be required that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I chose to terminate it.

Date: _____ Time: _____ AM/PM File No. _____

Patients Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian _____

Witness _____

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Do you have a specific dental problem? Describe _____ Please Circle
 Yes No
 Do you have dental examinations on a routine basis? Last visit _____
 Yes No
 Do you think you have active decay or gum disease? _____
 Yes No
 Do you brush and floss on a routine basis? Discuss _____
 Yes No
 Do your gums ever bleed? Discuss _____
 Yes No
 Do you like your smile? Why? _____
 Yes No
 Does food catch between your teeth? Any loose teeth? _____
 Yes No
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____
 Yes No
 Have your past experiences in a dental office always been positive? _____
 Yes No
 Do you smoke or chew? Any sores or growths in your mouth? Discuss _____
 Yes No
 Name of previous dentist (optional): _____
 Date of last full mouth x-rays (16 small films or panoramic) _____

Medical History

Are you under a physician's care now? Why? Who? _____ Yes No
 Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
 Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
 Are you taking any medications, pills, or drugs? What? _____ Yes No
 Are you on a special diet or have you taken Fen-Phen? Discuss _____ Yes No
 Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____
 WOMEN (please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you have, or have you ever had, any of the following conditions?

Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia (Bleeding Problem)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (Infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Medicines)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B (Serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Pollen/Dust)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
 Do you wish to talk to the dentist privately about any problem? _____ Yes No
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.
 DATE EXCEPTIONS PATIENT'S SIGNATURE BP REVIEWED BY
 _____ None _____ _____ Dr. _____
 _____ None _____ _____ Dr. _____
 _____ None _____ _____ Dr. _____

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle
 Address _____
Street City State Zip
 Home Phone (____) _____ Work Phone (____) _____ Social Security # _____ - _____ - _____
 Birthdate ____/____/____ If patient is a minor, give parent's/guardian's name _____
 If patient is a full-time student, fill in school name _____
 Emergency Contact _____ Phone (____) _____

Responsible Party Information

Name _____
Last First Middle Marital Status
 Residence _____
Street City State Zip
 Mailing Address _____
Street City State Zip
 Home Phone (____) _____ Work Phone (____) _____ Social Security # _____ - _____ - _____
 Birthdate ____/____/____ Relationship to patient _____
 Employer _____ Occupation _____
 Employer's Address _____
 Insurance Company _____ Group # _____
 Insurance Company Address _____
 Phone (____) _____

Secondary Insurance Information

If you have dual coverage, please fill out the following:
 Spouse's Name _____ Work Phone (____) _____
 Social Security # _____ - _____ - _____ Birthdate ____/____/____ Relationship to patient _____
 Employer _____ Occupation _____
 Employer's Address _____
 Insurance Company _____ Group # _____
 Insurance Company Address _____ Phone (____) _____

Payment Responsibility

For our patients without dental insurance ... I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients with dental insurance ... I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of all dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____
 Parent or Responsible Party _____ Relationship to Patient _____

PATIENT INFORMATION