

## *Welcome to Our Practice!*

*We are pleased that you have selected us to care for your dental needs and we look forward to your initial visit. Our goal is to make sure that our patients have healthy teeth and gums. We do this not only through treatment but with taking the time to explain exactly what care a patient needs.*

*We pride ourselves on our friendly staff and atmosphere. We strive to make your visit a pleasant experience and as comfortable as possible.*

*For your convenience we have enclosed some forms for you to fill out and bring to your first appointment. We have also enclosed a map to our office.*

*Should you have any questions before your visit please don't hesitate to call us at 302-741-2044.*

*Sincerely,*

*Robert R. Coope, D.D.S.*

Patient Name:

Birth Date:

Date Created:

Although dental personnel 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 dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes

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:

X \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If a Minor: Parent or Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Primary Dental Insurance & ID Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Secondary Dental Insurance & ID Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## FINANCIAL POLICIES

**\*PLEASE INITIAL NEXT TO EACH POLICY\***

\_\_\_\_ **PAYMENT:** Payment is due in **FULL** at the time of your appointment. We accept cash, credit cards and checks. There is a \$25 returned check fee. We also have zero interest payment plans available.

\_\_\_\_ **APPOINTMENT DEPOSIT:** A deposit is required to schedule any non-preventive (hygiene) appointment. This deposit is refundable and transferable if notice is given 1 day prior to change or cancel the appointment. The deposit will be forfeited if the patient fails to show up for the appointment without notice or emergency situation.

\_\_\_\_ **INSURANCE:** It is the responsibility of the patient to know the details of their insurance plan. Any amount that we tell you your insurance will pay is only an **ESTIMATE** and we **DO NOT** guarantee that it is the correct amount. If our estimate is incorrect we will send you a statement with your remaining balance.

\_\_\_\_ **PAST DUE ACCOUNTS:** If your account becomes past due, we will take any necessary steps to collect this debt. You agree that all of our expenses will be added to your past due amount. This includes but is not limited to collection agency fees, attorney fees and court fees. In case of a suit, you agree the venue shall be in Kent County, DE.

\_\_\_\_ **WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment in our office may become matter of public record.

**(Applies to Minors)**

\_\_\_\_ **DIVORCE:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account.

\_\_\_\_ If you are signing for your minor child you will continue to be financially responsible after your child reaches the age of 18 unless you initial below:

\_\_\_\_ Once my dependent is 18 he/she will be responsible for their own dental treatment and they will assume all financial responsibility.

**BY EXECUTING THIS AGREEMENT YOU ARE AGREEING TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN.**

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

## **ACKNOWLEDGEMENT OF HIPPA**

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE **NOTICE OF PRIVACY PRACTICES** AND HAVE NO QUESTIONS REGARDING THE CONTENT THEREIN.

PRINT PATIENT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

IF YOU WOULD LIKE A PERSONAL COPY OF THE **NOTICE OF PRIVACY PRACTICES (HIPPA)** PLEASE INITIAL HERE \_\_\_\_\_

ROBERT R. COOPE, D.D.S.

1250 South Governors Avenue • Dover, DE 19904 • (302) 741-2044 Office • (302) 741-2046 Fax

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the office of my dentist named above to release health information identifying me under the following terms and conditions:

1. For purposes of obtaining payment from insurance
2. To any other health professional for treatment purposes
3. For prescribing medications

I authorize the release of my medical information (including making or cancelling appointments) to the following people:

\_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize you to LEAVE A MESSAGE on the following regarding: (please initial)

Home phone- appointment message: \_\_\_\_ treatment message: \_\_\_\_ account information: \_\_\_\_

Cell phone – appointment message: \_\_\_\_ treatment message: \_\_\_\_ account information: \_\_\_\_

Work phone – appointment message: \_\_\_\_ treatment message: \_\_\_\_ account information: \_\_\_\_

Email/text – appointment message: \_\_\_\_ treatment message: \_\_\_\_ account information: \_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

If signing for the patient please, describe your relationship to the patient.

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Print Name

This authorization can be revoked at any time by written or electronic note telling us that your authorization is revoked. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. Send this note to the office listed at the top of the form.

Patient Health Questionnaire

1. Do you have any current concerns about your teeth?

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2. Do you drink coffee? Yes No If yes, how often? \_\_\_\_\_

3. Do you drink soda? Yes No If yes, how often? \_\_\_\_\_

4. Do you eat sweets/sugar? Yes No If yes, how often? \_\_\_\_\_

5. How often do you brush your teeth? \_\_\_\_\_. Do you use a hard bristle tooth brush? Yes No

6. How often do you floss your teeth? \_\_\_\_\_

7. Do you grind your teeth? Yes No I don't know

8. When was the last dental exam you had? \_\_\_\_\_  
What were the results of that exam?

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## **PAYMENT OPTIONS**

Payment is due at the time of service.  
WE ACCEPT CASH, CHECK OR CREDIT CARD

1. **A DEPOSIT IS REQUIRED TO SCHEDULE ANY NON-ROUTINE APPOINTMENTS.** All deposits are refundable if notice is given one day prior to the scheduled appointment. The deposit will be forfeited if notice is not received in a timely manner.
2. IF THE FULL TREATMENT FEE IS PAID AT THE TIME OF SCHEDULING A **5% DISCOUNT** on entire fee will be given. If patient has insurance, we will file the insurance but the insurance check will be sent to the patient. (Normally a check is received in 10-14 days)

OR

## **FINANCE OPTIONS**

We currently have (2) **ZERO INTEREST** payment plan options: Care Credit and Lending Club

These companies currently have 6 and 12 month no interest plans available. Simply make a monthly payment by the due date and pay the entire amount within the time period from purchase date and there is **ZERO** interest! These companies also offer **LOW INTEREST**, extended payment plans.

There are 3 ways to apply for these finance options:

1. Complete a paper application and we will submit the information and give you an instant answer.
2. Over the phone
3. Online

**PATIENT'S COPY**