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? _____

Time 12:10 PM | Robert R. Coope DDS PA | Date 3/11/2021

Patient Medical History

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? For What? Physician's Name?	◯ 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	
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	
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	

MEDICATIONS cont'd:_____

_____

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 ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Hepatitiis A ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No		

Have you ever had heart surgery? If yes please describe	◯ Yes ◯ No	If yes	
Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes	

Comments:

FOR OFFICE USE ONLY:

B/P_____

Temperature_____

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:_____

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 HIPAA

I ACKNOWLWDGE 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 (HIPAA)** PLEASE INITIAL HERE _____

CareFirst DENTAL TEAM

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?

   _____

   _____

   _____

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 your 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?

   _____

   _____

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