



**Patient Information:**

Patient Name \_\_\_\_\_  
M \_\_\_ F \_\_\_ Single \_\_\_ Married \_\_\_ Child \_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_  
Patient SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Patient's Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
  
Spouse's Name \_\_\_\_\_  
Spouse's DOB \_\_\_\_\_ Spouse's SSN \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_

**Parent/Guardian Information (if patient is a child):**

Mother \_\_\_\_\_ Relationship Mother \_\_\_ StepMother \_\_\_ Guardian \_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Father \_\_\_\_\_ Relationship Father \_\_\_ Step Father \_\_\_ Guardian \_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Who referred you to this office? \_\_\_\_\_  
What is the purpose of your visit? \_\_\_\_\_

**In Case of Emergency Contact:**

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_

**Dental Insurance:**

Who is responsible for this account? \_\_\_\_\_

Is Patient covered by insurance? YES \_\_\_ NO \_\_\_

Primary Insurance Company \_\_\_\_\_

Account Group Number \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Account Group Number \_\_\_\_\_

**Dental Insurance Estimates**

We are happy to file your dental claims for you as a courtesy. We ask that you pay your portion, and we will file for the insurance portion. We make every effort to estimate your part according to the information we receive from each insurance company, but we are not always able to estimate accurately because of deductibles, maximums, and allowances that may be specific to the insurance plan.

**I agree to be responsible for any balance that the insurance company does not pay.**

I certify that I have insurance coverage and assign directly to this office all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. **I agree to authorize the dentist to release all information necessary to secure the payment of benefits. I agree to authorize the use of this signature on all insurance submissions.**

**Appointment Policy:**

Broken appointments make it difficult to maintain, both, a timely schedule for our patients and efficiency for our staff. If you find it necessary to cancel your appointment, we request you provide our office with 24 hours notice. Multiple failure of this notification may result in dismissal from Cooper Family Dentistry. **We must be able to contact you 24-48 hours before your appointment to confirm.** We must have working phone numbers to contact you. **If we leave a message, please call us back to confirm or you may be at risk of losing your appointment.**

If you have confirmed your appointment and do not call or show at your scheduled time, then Cooper Family Dentistry may be unable to reschedule your appointment.

**A fee of \$25.00 will be charged for appointments cancelled with less than 24 hour notice.**

I understand and agree to the above. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of staff responsible for any errors or omissions that I have made in the completion of this form.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Check Any Conditions below that you have or have had:**

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Aids                    | <input type="checkbox"/> Rheumatic fever           | <input type="checkbox"/> Latex Allergy        | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Heart Disease or murmur | <input type="checkbox"/> Loss of Weight            | <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Sore that won't heal | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Swelling Ankles         | <input type="checkbox"/> Any History surgery _____ |   |                                       |
| <input type="checkbox"/> Irregular Heartbeat     | <input type="checkbox"/> Pregnancy                 | <input type="checkbox"/> Joint Replacement    |                                       |
| <input type="checkbox"/> Heart Valve Replacement |  |   |                                       |

**Allergies?**

- |  |  |
|--|--|
| <input type="checkbox"/> Penicillin            | <input type="checkbox"/> Morphine        |
| <input type="checkbox"/> Latex Allergy         | <input type="checkbox"/> Serums          |
| <input type="checkbox"/> Aspirin               | <input type="checkbox"/> "Mycins"        |
| <input type="checkbox"/> Codeine               | <input type="checkbox"/> Any Antibiotics |
| <input type="checkbox"/> Any Other Drugs _____ |  |

**What medications are you currently taking?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever taken Fosamax, Bonivia, Actonel or any other cancer medications containing bisphosphonate?  YES  NO

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of staff responsible for any errors or omissions that I have made in the completion of this form.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

In the future, we will be able to send an email or text message to confirm your appointments.

Would you like to receive email reminders? YES \_\_\_ NO \_\_\_

Would you like to receive text reminders? YES \_\_\_ NO \_\_\_

Please provide your email address:

Email Address:
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Please provide your mobile phone number:

Mobile phone number:
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Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Our Policy of Care and Payment**

**Fees and Payments:**

All balances are due in full at the time of service, unless other arrangements are made prior to the start of treatment. Any account that payment has not been received within 90 days will be considered for collection by an outside agency. For your convenience, our office offers the following method of payment:  
CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.  
(applications are available upon request)

\_\_\_\_\_  
Signature of Patient/ Responsible Party

\_\_\_\_\_  
Date

**Oral Abnormality Screening Consent Form**

**We are very concerned about oral cancer, and conduct screening examinations on every patient.**

The incidence of Oral Cancer continues to rise in the United States. The American Cancer Society indicates that this is the eighth year in a row in which there has been an increase in the rate of occurrence of oral cancers, in 2007 there was a major jump of over 11% in that single year. Approximately 43250 people in the US will be newly diagnosed with oral cancer this year.

**Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age, tobacco and alcohol use.**

Traditionally, dentists and hygienists have done oral cancer screenings with the naked eye, but recently a new technology, the **VELscope** had received the FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back to the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened and much like "desert storm night vision technology" the clinician can see changes in tissue that may not be visible to the naked eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

**The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurance. The fee for this enhanced examination is \$15.00. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.**

**Please sign the area below to accept the financial responsibility for this procedure.**

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

<p><b>YES</b> <b>I authorize the office to perform the VELscope examination.</b></p> <p>Print Name _____</p> <p>Signature _____ Date _____</p>
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<p><b>NO</b> <b>I decline to have the VELscope examination.</b></p> <p>Print Name _____</p> <p>Signature _____ Date _____</p>
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We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. Initials \_\_\_\_\_

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Brandy O'Hare  
204 Country Club Rd  
Sherwood, AR 72120  
501.835.2232

For more information about HIPAA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
202.619.0257  
Toll Free: 1.877.696.6775

Notice of Privacy Practices Acknowledgement  
Cooper Family Dentistry  
204 Country Club Rd  
Sherwood, AR 72120

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ❖ Obtain payment from third-party payers
- ❖ Conduct normal healthcare operations such as quality assessments and physical certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to release my information to the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_