COOPER
FAMILY DENTISTRY

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 _____

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

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 ____

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 canceled with less than 24 hour notice.

I understand and agree with 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:

_ Aids
_Heart Disease
_Heart Murmur
_Heart Valve Replacement
_Irregular Heartbeat
_Diabetes Type A or Type B
_High Blood Pressure
_Asthma
_Dementia/Alzheimer's
_Mental Disorder
_Bleeding Disorder
_Blood Disease (type)_____
_HIV Positive
_Herpes
_Any Surgery History

_Currently Pregnant (week) _____
_Autoimmune
_Epilepsy
_Blood Thinners
_HPV
_Sensory Disorder
_ADD/ADHD
_Dry Mouth
_Sleep Apnea
_Joint Replacement (Dates?)_____
_Cancer (Specify)_____ Radiation: yes no
_Hepatitis (type)_____
_Stroke (date)_____

_____

_____

_Other (Please Specify)

_____

Allergies?

_ Penicillin _ Morphine
_ Latex Allergy _ Serums
_ Aspirin _ "Mycins"
_ Codeine _ Any Antibiotics
_ Any Other Drugs _____

What medications are you currently taking?

_____

_____

_____

Have you ever taken Fosamax, Boniva, 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:

Please provide your mobile phone number:

Mobile phone number:

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.

YES
I authorize the office to perform the VELscope examination.

Print Name
_____

Signature _____ Date _____

NO
I decline to have the Velscope examination.

Print Name
_____

Signature _____ Date _____

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:

Jennifer Dunlap
308 North James St
Jacksonville, AR. 72076
501.982-7547

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
308 North James St.
Jacksonville, AR. 72076

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 _____