J.D. COOPER
3363 TATES CREEK ROAD
SUITE 201
LEXINGTON, KY 40502

We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone _____

Address: _____
Street Apartment # E-MAIL ADDRESS

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Dizziness / Fainting
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths / Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- Heart Murmur / MVP
- ☐ Diabetes
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Kidney Disease

DRUG ALLERGIES

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other_____

WOMEN

- ☐ Are you pregnant?

Due Date:_____

- ☐ Taking birth control

Dental History

- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side of Mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clench/ Grind Teeth
- ☐ Gums swollen or tender
- ☐ Jaw Pain or tiredness
- ☐ Loose teeth
- ☐ Mouth Breathing
- ☐ Othodontic Treatment
- ☐ Broken filling(s)
- ☐ Wisdom teeth removed
- ☐ Wisdom teeth Pain
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Teeth Sensitivity To Sweets/Cold

How often do you floss?

_____

How often do you brush?

- Do you take antibiotics for dental appointments?_____If so what antibiotic do you take:_____
- Are you taking Coumadin or other blood thinners? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
  ☐ Prescribed Medications and over the counter medications: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Responsible Party Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone or Pager: _____

Address:_____
Street Apartment #

_____
City State Zip Code **E-MAIL ADDRESS**

Responsible Party
Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Internet ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services and Financial Responsibilities

I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, or guardian

Consent to wireless telephone calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the dental office to the contrary in writing. In this section, calls and texts messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing services or other computer assisted technology or by clinical providers, attorneys or its agents including collection agencies.

Consent To Email Usage

If any time I provide an email address at which I may be contacted, unless I notify the dental office to the contrary in writing, I consent to receiving statements, and payment receipts at the email address from the office.

_____ Date:_____ Relationship to Patient _____
Signature of patient, or guardian

Agreement for Payment for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who have dental insurance understand that all dental services furnished will be charged directly to the insurance company. He or she is personally responsible for payment of all dental services regardless of what your insurance company pays. This office will prepare the patients insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the estimate listed for my dental care can only be extended for a period of three months from the date of the patient exam.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

No Interest Payment Plans for 3,6 or 12 Months*
Minimum Purchase Required:
Minimum Payments Required:

$150 for 3 months No Interest Plans $250 for 6 months No Interest Plans
$500 for 12 months No Interest Plans

Methods of Payment:

Cash **Check**
Visa **Citi Bank (health care finance)**
Master Card **Money Order**

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Consent for Patient Information/Records Release

I grant my permission for Dr. Cooper and/or affiliates to disclose any and all information pertaining to my Treatment Plan, Health History, and/or financial records to the person(s) listed below:

Name:_____ Relationship to patient: _____

Name:_____ Relationship to patient: _____

_____ Date: _____
Signature of patient, parent or guardian

James D. Cooper, DMD
3363 Tates Creek Rd., Suite 201
Lexington, KY 40502

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996 http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone:
Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dr. James D Cooper, DMD 3363 Tates Creek Rd. Ste 201 Lexington, KY 40502 (859) 266-2570

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records. HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

You May Refuse to Sign This Acknowledgement*

I, _____, have received acknowledgement of this office's Notice of Privacy Practices.

_____ February 8, 2017
Signature

For Office Use:
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
☐☐ ____ Communications barriers prohibited obtaining the acknowledgement
☐ ☐☐ ____ An emergency situation prevented us from obtaining acknowledgement
☐ ☐☐ ____ Other (Please Specify) _____