

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.

Child information

Your Child: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____
Child's Social Security #: _____ Birth Date: _____
Phone (Home): _____ School: _____ Grade: _____
Child's Home Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for that visit: _____

Has your child ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- AIDS/HIV
- Allergies _____
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Chemotherapy
- Congenital Heart Defect
- Diabetes

- Epilepsy
- Excessive Bleeding
- Eye Disorders
- Handicaps/Disabilities
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur / MVP
- Hepatitis / Jaundice
- Immune Disorders
- Kidney Disease
- Latex Allergy
- Liver Disorders

DRUG ALLERGIES

- Codeine Allergy
- Penicillin Allergy
- Other Drug Allergies

- Severe Gag Reflex
- Suck/ Bite Lip
- Suck Thumb/ Finger
- Wisdom Teeth removed

DENTAL HISTORY

- Bad Breath
- Bite/ Chew Nails
- Biteguard Therapy
- Bleeding Gums
- Bleaching Treatment
- Blisters/ Sores on Lips
- Clench/ Grind Teeth

- Mouth Breathing

- Has your child ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Is your child under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
 Prescribed Medications: _____
- Does your child have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Has your child had orthodontic treatment? _____ If so when _____

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: _____

Parent or Responsible Party Information

The following is: Mother Stepmother Father Stepfather Guardian

Name: _____
 Male Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____ Cell Phone (optional) _____

Street

Apartment #

City

State

Zip Code

E-MAIL ADDRESS

Responsible Party

Employer Name: _____ Occupation: _____

Address: _____

Street

City,

State Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

Signature of parent or guardian

Date: _____

Relationship to Patient: _____

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: _____ E-mail: _____
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.

REVOCAION 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.

Signature Date _____

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) _____