COHIL FAMILY DENTISTRY
FAMILY, COSMETIC, AND RESTORATIVE DENTISTRY

ADULT MEDICAL HISTORY

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment [ ] Examination [ ] Emergency [ ]Consultation

DENTAL HISTORY

Do you have a specific dental problem? Describe _____ [ ]Yes[ ]No

Do you like your smile? Why? _____ [ ]Yes[ ]No

Does food catch between your teeth? Any loose teeth? [ ]Yes[ ]No
_____

Do you want to keep your remaining teeth? [ ]Yes[ ]No
_____

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? [ ]Yes[ ]No
_____

Have your past experiences in a dental office always been positive? [ ]Yes[ ]No
_____

Do you have dental examinations on a routine basis? Last Visit _____ [ ]Yes[ ]No

Name of previous dentist (optional) _____

Date of last full mouth xrays (16 small films or panoramic) _____

MEDICAL HISTORY

Physician's Name _____ Phone_____

Have you been under the care of a physician in the past two years? Why ? [ ]Yes[ ]No
_____

Have you ever had a serious injury to your head or neck? Discuss [ ]Yes[ ]No
_____

Are you taking any medications, pills or drugs? What? [ ]Yes[ ]No
Medication _____ Reason _____
Medication _____ Reason _____
Medication _____ Reason _____
Medication _____ Reason _____

Do you use tobacco products of any kind? [ ]Yes[ ]No
_____

Are you allergic to any medications or substances? Please check box below [ ]Yes[ ]No
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Other_____

Women (please mark) [ ] Pregnant [ ] Nursing [ ] Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes. If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	[ ]	[N]	Lung Trouble (TB , asthma , emphysema)	[ ]	[N]	Artificial Joint	[ ]	[N]
* Heart Murmur	[ ]	[N]				Venereal Disease	[ ]	[N]
Irregular Heart Beat	[ ]	[N]	Breathing Problem	[ ]	[N]	HIV Positive/AIDS	[ ]	[N]
Angina/Chest Pain	[ ]	[N]	Hay Fever	[ ]	[N]	Chemical/Alcohol Dependency	[ ]	[N]
Heart Attack/Failure	[ ]	[N]	Sinus Trouble	[ ]	[N]			
* Congenital Heart Disorder	[Y]	[N]	Cancer	[ ]	[N]	Cold Sores	[ ]	[N]
* Mitral Valve Prolapse	[ ]	[N]	Radiation Treatment	[Y]	[N]	Herpes	[ ]	[N]
Scarlet Fever	[ ]	[N]	Chemotherapy	[ ]	[N]	Stroke	[ ]	[N]
Rheumatic Fever	[ ]	[N]	Stomach/Intestinal Disease	[Y]	[N]	Convulsions	[ ]	[N]
* Artificial Heart Valve	[ ]	[N]	Diabetes	[ ]	[N]	Epilepsy or Seizures	[ ]	[N]
Heart Pace Maker	[ ]	[N]	Liver Disease/Hepatitis	[ ]	[N]	Fainting or Dizziness	[ ]	[N]
High Blood Pressure	[ ]	[N]	Kidney Problems	[ ]	[N]	Glaucoma	[ ]	[N]
Blood Disease	[ ]	[N]	Renal Dialysis	[ ]	[N]	Tumors or Growths	[ ]	[N]
Bruise Easily/Anemia	[ ]	[N]	Thyroid Disease	[ ]	[N]	Nervousness	[ ]	[N]
Bleeding Problem	[ ]	[N]	Arthritis/Gout	[ ]	[N]	Psychiatric Care	[ ]	[N]
			Frequent Headaches	[ ]	[N]	Alzheimer's Disease	[ ]	[N]

Do you have another, disease, condition or problem not listed? [ ] Yes [ ]No

Have you ever had any other serious illness not checked above? Discuss [ ] Yes [ ]No

_____

Do you wish to talk to the dentist privately about any problem? [ ]Yes [ ]No

_____

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or medications, I shall inform the dentist and staff prior to or at my next dental appointment without failure.

Date

PATIENT NAME (PARENT/GUARDIAN) _____ _____

Signature:_____

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings

MEDICAL UPDATES

Date Changes Patient's Signature BP Reviewed By

_____ _____ _____ _____ Dr. _____

New Meds: _____

Date Changes Patient's Signature BP Reviewed By _____ Dr.

_____ _____ _____ _____

New Meds: _____

Date Changes Patient's Signature BP Reviewed By _____ Dr.

_____ _____ _____ _____

New Meds: _____

COHIL FAMILY DENTISTRY
FAMILY, COSMETIC, AND RESTORATIVE DENTISTRY

OFFICE POLICIES AND GOALS

Our Financial Policy

Thank you for choosing us to serve your dental health needs. We are commi□ed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to your treatment. All pa□ents must complete the Pa□ent Informa□on form, HIPPA, and the Office Policies and Goals form.

- Full payment (or the "es□mated pa□ent por□on", if insured) is due at □me of service
- We accept cash, debit, and credit cards.
- We do offer an extended payment plan with prior credit approval
- You are responsible for your account with the office (regardless of whether insurance is involved). This includes upda□ng insurance informa□on when it has changed.

Regarding Insurance

We consider our fees to be a ma□er between you and our office, regardless of insurance coverage. Rarely does an insurance plan cover all expenses involved in treatment other than preventa□ve care, which is usually (but not always) covered at 100%. (Some□mes there is a deduc□ble involved for preventa□ve care). We take pride in doing everything possible to help our pa□ents u□lize and maximize their insurance benefits. We file insurance as a courtesy to our pa□ents. Please understand that every effort is made to let you know what your es□mated por□on may be from your insurance company. We also will provide you with what your es□mated financial responsibility for that visit will be. We do expect your es□mated por□on paid on day of service. All benefits are es□mated and are not a guarantee for payment. The insurance policy is a contract between you and your insurance company. We are not party to that contract. Our office allows 60 days for benefits to be received in this office from the day of treatment. A□er that □me, you are expected to reconcile your balance immediately. Again, we do everything possible to assist the insurance company to make benefit payment in a □mely manner. To keep you informed of processing your claim, the insurance company should send you a copy of the "explana□on of benefits". This is printed on the insurance form a□er treatment is performed.

Missed Appointments

Each of your scheduled appointments is a designated □me that has been "*reserved*" just for you! We respect your □me and ask that our pa□ents in turn, do the same for us. If you should find that your appointment needs to be changed, a 24 hour no□ce is required. A cancella□on fee of $50 will be charged to those not fulfilling this requirement. Please help us serve you be□er by keeping your scheduled appointment(s).

Minors

The adult accompanying a minor and the parent(s) or guardian is responsible for full payment (es□mated por□on due, if insured). For unaccompanied minors, payment arrangements must be made in advance with payment accompanying the minor the day of treatment. Thank you for understanding our financial policies and goals for service to our pa□ents. We thank you for choosing us to serve your dental health needs! Please let us know if you have any ques□ons or concerns.

Authoriza□on

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medica□ons and perform such diagnos□c and therapeu□c procedures as may be necessary for proper dental care. I further understand that a finance, rebilling, collec□on charge and/or a□orney fees will be added to any overdue balance. In the event there is a dispute, the prevailing party, is awarded any and all a□orney and collec□on fees. The informa□on on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to the den□st to release my dental/medical histories and other informa□on about my dental treatment to third party payers and/or other health professionals.

X_____

☐ Adult ☐ Father (or husband) ☐ Mother (or wife) ☐ Guardian

Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

_____ **I decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

This form does not constitute legal advice and covers only federal, not state, law.

Kirk K. Cohil, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

PATIENT INFORMATION (CONFIDENTIAL)

407.889.9682
COHIL FAMILY DENTISTRY
FAMILY, COSMETIC, AND RESTORATIVE DENTISTRY

NAME_____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY_____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE_____

SS#/SIN_____ BIRTHDATE _____

CHECK APPROPRIATE: ____MINOR ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED IF

COLLEGE STUDENT: F.T./P.T. NAME OF SCHOOL _____ CITY_____STATE_____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____ EXT _____

BUSINESS ADDRESS_____CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME_____ EMPLOYER _____ WORK # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ STATE _____ ZIP _____HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE_____ SS#/SIN _____

EMPLOYER_____ WORK PHONE_____ EXT _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? _____YES _____NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE_____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____ EXT_____

EMPLOYER ADDRESS _____ CITY _____STATE____ZIP_____

INSURANCE CO. _____ PHONE #_____ GROUP # _____ POLICY/ID #_____

INSURANCE CO. ADDRESS _____ CITY _____STATE _____ ZIP_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___YES ___NO **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE_____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____ EXT_____

EMPLOYER ADDRESS _____ CITY_____STATE____ZIP_____

INSURANCE CO. _____ PHONE #_____GROUP #_____ POLICY/ID #_____

INSURANCE CO. ADDRESS _____ CITY _____STATE _____ ZIP_____

X _____ SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR