



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	☐	☐	Lung Trouble	☐	☐	Artificial Joint	☐	☐
* Heart Murmur	☐	☐	(TB , asthma , emphysema)	☐	☐	Venereal Disease	☐	☐
Irregular Heart Beat	☐	☐	Breathing Problem	☐	☐	HIV Positive/AIDS	☐	☐
Angina/Chest Pain	☐	☐	Hay Fever	☐	☐	Chemical/Alcohol	☐	☐
Heart Attack/Failure	☐	☐	Sinus Trouble	☐	☐	Dependency	☐	☐
* Congenital Heart Disorder	☐	☐	Cancer	☐	☐	Cold Sores	☐	☐
* Mitral Valve Prolapse	☐	☐	Radiation Treatment	☐	☐	Herpes	☐	☐
Scarlet Fever	☐	☐	Chemotherapy	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Stomach/Intestinal Disease	☐	☐	Convulsions	☐	☐
* Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Epilepsy or Seizures	☐	☐
Heart Pace Maker	☐	☐	Liver Disease/Hepatitis	☐	☐	Fainting or Dizziness	☐	☐
High Blood Pressure	☐	☐	Kidney Problems	☐	☐	Glaucoma	☐	☐
Blood Disease	☐	☐	Renal Dialysis	☐	☐	Tumors or Growths	☐	☐
Bruise Easily/Anemia	☐	☐	Thyroid Disease	☐	☐	Nervousness	☐	☐
Bleeding Problem	☐	☐	Arthritis/Gout	☐	☐	Psychiatric Care	☐	☐
			Frequent Headaches	☐	☐	Alzheimer's Disease	☐	☐

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: _____

OFFICE POLICIES AND GOALS

Our Financial Policy

Thank you for choosing us to serve your dental health needs. We are committed 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 patients must complete the Patient Information form, HIPPA, and the Office Policies and Goals form.

- Full payment (or the “estimated patient portion”, if insured) is due at time 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 updating insurance information when it has changed.

Regarding Insurance

We consider our fees to be a matter between you and our office, regardless of insurance coverage. Rarely does an insurance plan cover all expenses involved in treatment other than preventative care, which is usually (but not always) covered at 100%. (Sometimes there is a deductible involved for preventative care). We take pride in doing everything possible to help our patients utilize and maximize their insurance benefits. We file insurance as a courtesy to our patients. Please understand that every effort is made to let you know what your estimated portion may be from your insurance company. We also will provide you with what your estimated financial responsibility for that visit will be. We do expect your estimated portion paid on day of service. All benefits are estimated 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. After that time, you are expected to reconcile your balance immediately. Again, we do everything possible to assist the insurance company to make benefit payment in a timely manner. To keep you informed of processing your claim, the insurance company should send you a copy of the “explanation of benefits”. This is printed on the insurance form after treatment is performed.

Missed Appointments

Each of your scheduled appointments is a designated time that has been “reserved” just for you! We respect your time and ask that our patients in turn, do the same for us. If you should find that your appointment needs to be changed, a 24 hour notice is required. A cancellation fee of \$50 will be charged to those not fulfilling this requirement. Please help us serve you better by keeping your scheduled appointment(s).

Minors

The adult accompanying a minor and the parent(s) or guardian is responsible for full payment (estimated portion 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 patients. We thank you for choosing us to serve your dental health needs! Please let us know if you have any questions or concerns.

Authorization

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 medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I further understand that a finance, re-billing, collection charge and/or attorney fees will be added to any overdue balance. In the event there is a dispute, the prevailing party, is awarded any and all attorney and collection fees. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____

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

Date _____

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☐ 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

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

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

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