



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

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 \_\_\_\_\_ 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 \_\_\_\_\_

**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