COSIC DENTAL

PATIENT INFORMATION

Today's Date _____/_____/_____

Name _____ DOB _____/_____/_____

Address _____

City _____ State _____ Zip _____ Years at this residence_____

Home Phone # (_____) _____-_____ Cell # (_____) _____-_____ Work # (_____) _____-_____

Employer _____ Occupation _____ Years employed _____

SSN _____-_____-_____ Pharmacy _____ Physician _____

E-mail Address _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Other

RESPONSIBLE PARTY

Complete portion below if patient is 17 years of age or younger

Name _____ DOB _____/_____/_____

Address _____ Years at this residence_____

Home Phone # (_____) _____-_____ Cell # (_____) _____-_____ Work # (_____) _____-_____

Employer _____ Occupation _____ Years employed _____

SSN _____-_____-_____ Relationship to patient _____

E-mail Address _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Other

EMERGENCY CONTACT

Name _____ Relationship to patient _____

Home Phone # (_____) _____-_____ Cell # (_____) _____-_____ Work # (_____) _____-_____

Address _____

INSURANCE

Member's Name _____ DOB _____/_____/_____

Home/Cell Phone # (_____) _____-_____ Employer Name _____

Name of insurance company _____ ID # _____

Who may we thank for referring you? _____

How did you hear of us? _____

I understand that where appropriate, credit bureau reports may be obtained. *(Responsible party if minor)*

Signature _____

Updates (date & initial) _____, _____, _____, _____

Patient Name _____ DOB _____ Today's date _____

MEDICAL CONDITIONS *(Please select all that apply.)*

☐ Asthma	☐ Bleeding problems	☐ Prosthetic heart valve	☐ Epilepsy
☐ Artificial Joint	☐ Hepatitis	☐ Tuberculosis	☐ HIV/AIDS
☐ Cancer	☐ Chemo/Radiation	☐ Breathing Problems/COPD	☐ Steroid Use
☐ Kidney Problems	☐ Hypertension	☐ Psychiatric Therapy (this yr)	☐ Vertigo
☐ Any Addiction	☐ Any changes in health	☐ Congestive Heart Failure	

Any other medical conditions:

_____

Medications you take:

_____

Do you take blood thinners? (Example: Coumadin, Plavix, etc.) ☐ Yes ☐ No

If yes, date _____ *and score of most recent INR* _____

What is your level of anxiety/stress/fear when going to the dentist?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Temporomandibular Joint Symptoms:

- ☐ Do you have any jaw pain or headaches?
- ☐ Are your headaches (if any) frequent or severe?
- ☐ Do you snore?
- ☐ Does it hurt to open wide/yawn/chew?
- ☐ Do you take muscle relaxers or pain relievers?
- ☐ Do you use a CPAP/BIPAP device for sleeping?

Have you ever had an adverse/allergic reaction to:

☐ Local anesthetics	☐ Novocain	☐ Codeine	☐ Latex
☐ Antibiotic _____		☐ Aspirin/Advil	☐ Other _____

Gum and Heart Disease: Do you have any of the following? *(Please select all that apply.)*

- ☐ Family history of gum disease
- ☐ Previous bouts of gum disease/gingivitis
- ☐ Osteoporosis
- ☐ Previous tobacco user
  When did you quit? _____
- ☐ Stress (death in family, injury, illness, etc.)
- ☐ Spouse with gum disease
- ☐ Current tobacco user *What kind* _____
  How much daily _____
  For how long _____
- ☐ Taking Dilantin, CA+ Channel Blockers, or Immunosuppressant for organ transplantation

Have you been diagnosed with heart disease/stroke? ☐ Yes ☐ No

Do you have any of the following risk factors? *(Please check all that apply.)*

☐ Family history of heart disease ☐ Tobacco use ☐ High cholesterol ☐ High blood pressure

Are you a diabetic?

- ☐ Yes, I am..... **How is your diabetes control?** ☐ Good ☐ Fair ☐ Poor
- ☐ No, I am not..... **Any family history of diabetes?** ☐ Yes ☐ No

Do you have any of these warning signs of diabetes?

☐ Frequent urination ☐ Excessive thirst/hunger ☐ Weakness/fatigue ☐ Slow healing of cuts

☐ Unexpected weight loss

Have you been diagnosed with Rheumatoid Arthritis? ☐ Yes ☐ No
Do you have a family history of Alzheimer's? ☐ Yes ☐ No

Women, are you:
☐ Pregnant? ☐ Nursing? ☐ Taking birth control pills? ☐ Post-menopausal?

Do you have osteoporosis? ☐ Yes ☐ No
Have you been tested for osteoporosis? ☐ Yes ☐ No

Do you have any of the following risk factors for osteoporosis? *(Please check all that apply.)*
☐ Post-menopausal ☐ Rheumatoid arthritis ☐ Family history of osteoporosis
☐ Inadequate exercise ☐ Early menopause ☐ Tobacco use/smoking

Have you ever taken:
Fosamax, Fosamax Plus D, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors, or *Zometa* for osteoporosis or for any other reason? ☐ Yes ☐ No

OTHER HEALTH QUESTIONS

Are you having any pain or discomfort at this time?	☐ Yes	☐ No
Have you ever had a bad experience in a dental office?	☐ Yes	☐ No
Have you been a patient in the hospital during the past two years?	☐ Yes	☐ No
Have you been under the care of a medical doctor during the past two years?	☐ Yes	☐ No

I understand that the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

X _____ Date _____

CONSENT:
The undersigned hereby authorizes Doctor(s) to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor(s) to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor(s) to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection on this note.

X _____ Date _____

Witness _____

Parent or Responsible Party Signature _____

Relationship to Patient _____

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice o the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this _____ day of _____20____

Print Patient Name_____

Signature_____

Relationship to Patient_____