PATIENT INFORMATION

Welcome to Cope Dentistry. To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name_____ **Preferred name** _____**Birth date**_____

If minor, parents names _____**Cell phone** _____**Home phone**_____

Mailing Address _____**City** _____**State** _____ **Zip** _____

Employer_____ **Occupation**_____ **Work phone** _____

E-Mail address _____**Preferred method to be reached**_____

Spouse's name _____**Spouse's employer**_____ ___**Unmarried**

BILLING.CREDIT AND INSURANCE INFORMATON: Covered by dental insurance: ___Yes ___No

Your Social Security number_____

Your Dental Insurance Company _____**Group number**_____ **Member ID Number** _____

Covered by spouse's insurance? ___Yes ___No Spouse's dental insurance company _____**Group number**_____

Spouse Member ID Number _____**Spouse's birthday**_____ **Spouse Social Security number**_____

Whom may we thank for referring you to our office? _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check all that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Pacemaker
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Allergies or hives
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Neurologic condition
- ❑ Artificial joint or valve
- ❑ Epilepsy, seizures, or fainting spells
- ❑ High or low blood pressure
- ❑ Emotional disorder
- ❑ Arthritis
- ❑ Tuberculosis or other lung problems
- ❑ Herpes or cold sores
- ❑ Kidney disease
- ❑ AIDS or HIV positive
- ❑ Hepatitis or other liver disease
- ❑ Migraine headaches or frequent headaches
- ❑ Alcoholism
- ❑ Anemia or blood disorders
- ❑ Hay fever or sinus trouble
- ❑ Asthma
- ❑ Do you smoke or use chewing tobacco? ___Yes ___ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Penicillin or other antibiotics
- ❑ Latex materials
- ❑ Local Anesthetics (Novocain)
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin, Acetaminophen or Ibuprofen
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Blood thinners
- ❑ Non- prescription drugs/supplements
- ❑ Nitroglycerin or other drugs for heart trouble
- ❑ Cortisone or other steroids
- ❑ Antibiotics
- ❑ High blood pressure drugs
- ❑ Antidepressants
- ❑ Insulin or other diabetic drug
- ❑ Osteoporosis (bone density) drugs
- ❑ Other_____

Women:

- ❑ Are you pregnant?
- ❑ Taking hormones or contraceptives.

Name of your physician: _____

Have you been in the hospital in the last 2 years? If so, for what reason? _____

Do you have any disease, condition, or problem not listed above?_____

How long has it been since you've seen a dentist?_____ **Reason for today's visit?** _____

Please add anything else you would like us to know about. _____

Signature of patient (or parent) _____**Date**_____

COPE DENTISTRY, P.A.

Susan A. Cope, D.D.S. John M. Cope, D.D.S. Lindy A. Cope, D.D.S

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Print Name

_____

Date

For Office Use Only

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 the acknowledgement
Other (Please specify)

_____

_____

_____

05/2016