COOPER
FAMILY DENTISTRY
501.982.7547
GENERAL & IMPLANT DENTISTRY FOR THE ENTIRE FAMILY

Patient Name_____
M__F__ Single__ Married__
Address_____
City_____ **State**_____ **Zip**_____

Email Address_____

Patient SSN _____ **Age**_____ **Birth Date**_____

Home Phone_____ **Work**_____ **Cell Phone**_____

Spouse's Name_____
Spouse's DOB_____ **Spouse's SSN**_____
Spouse's Employer_____

Patient's Employer_____ **Address**_____

City_____ **State** _____**Zip** _____

Who referred you to this office? _____
What is the purpose of your visit? _____
In Case Of Emergency Contact:
Name_____ **Phone #**_____
Relationship_____

Check Any Conditions below that you have or have had:

__Aids	__Rheumatic fever	__Latex Allergy	__Asthma
__Heart Disease or murmur	__Loss of Weight	__Bleeding Disorder	__Hepatitis
__Neck Pain	__Cancer	__Herpes	__Stroke
__Diabetes	__High Blood Pressure	__Sore that won't heal	__HIV Positive
__Swelling Ankles	__Any history surgery_____		
__Irregular Heartbeat	__Pregnancy	__Joint Replacement	
__Heart Valve Replacement			

Allergies?
__Penicillin __Morphine
__Latex Allergy __Serums
__Aspirin __"Mycins"
__Codeine __Any Antibiotics
__Any Other Drugs_____

What medications are you currently taking?
_____
_____
_____

Dental Insurance:
Who Is Responsible For This Account? _____
Is Patient Covered By Insurance? YES___ NO___
Primary Insurance Company_____
Account Group Number_____
Secondary Insurance Company_____
Account Group Number_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of staff responsible for any errors or omissions that I have made in the completion of this form.

Printed Name_____
Signature_____ **Date**_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

*Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

* Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

* Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. This contact may involve leaving a message on an answering machine or voice mail.

Any other uses and disclosures will be made only with your written authorizations. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

* The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

* The right to inspect and copy your protected health information.

* The right to amend your protected health information.

* The right to receive an accounting of disclosures of protected health information.

* The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

*The right to provide and we are obligated to receive written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Initials_____

Please contact us for more information:

Marilyn Vann
Cooper Family Dentistry
308 N. James Street
Jacksonville, AR 72076
501-982-7547

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement
Cooper Family Dentistry
308 N. James Street
Jacksonville, AR 72076

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers

* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____
Relationship to Patient_____
Signature_____
Date_____

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Our Policy of Care and Payment

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called Care Credit that allows you to start treatment today and spread payments over time.

Payment Options Include: Cash or check, Major Credit Cards, Care Credit.

Applying for Care Credit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account: *check one*

- o Cash or Check
- o Major Credit Card
- o Care Credit

_____ _____
Signature of Patient/Responsible Party Date

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Dental Insurance Estimates

We are happy to file your dental claims for you as a courtesy. We ask that you pay your portion, and we will file for the insurance portion. We make every effort to estimate your part according to the information we receive from each insurance company, but we are not always able to estimate accurately because of deductibles, maximums, and allowances that may be specific to the insurance plan.

I agree to be responsible for any balance that the insurance company does not pay.

I certify that I have insurance coverage and assign directly to this office all insurance benefits if any otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. **I agree to authorize the dentist to release all information necessary to secure the payment of benefits. I agree to authorize the use of this signature on all insurance submissions.**

Signature_____ Date_____