COOPER DENTAL GROUP

PATIENT HISTORY

Personal Information

Patient Name Mr/Mrs/Miss/Ms _____MI_____ Sex : M / F Birthdate _____
Address _____SSN#_____
City_____ State _____ Zip_____
Home Phone_____ Work Phone _____ Cell Phone _____
Patient Email (or Guardian)_____
Responsible Party _____SSN#___-___-____ Birthdate _____
Spouse Mr/Mrs_____ SSN#___-___-____ Birthdate _____
Whom May We Thank For Referring You? _____

Employer Dental Insurance Information

Name of Insured Employee_____ Relationship to patient _____
Insured's Employer_____ Phone _____
Spouse Employer _____Phone _____
Dental Insurance Co. _____Phone_____ Group # _____
Address _____City/State_____Zip_____
Coverage: Family _____ Self and Dependents _____ Self Only_____ Children Only_____ Parents Only _____
Do you have additional dental Insurance? Yes / No Please present all dental Insurance cards to receptionist.

Medical History Information

CIRCLE the conditions that apply to you: NONE

Anemia
Arthritis
Asthma
Cancer/Radiation Tx
Diabetes
Epilepsy
Excessive bleeding
Fainting
Hay Fever
Heart Murmur
Heart Trouble
Hepatitis A B or C
Herpes Virus
High Blood Pressure
HIV Positive/AIDS
Joint Replacement
Kidney Disease
Low Blood Pressure
Mitral Valve Prolapse
Neck/Head Pain
Nursing
Pacemaker
Pregnant
Rheumatic Fever
Sinus Trouble
Stroke
TB/Lung Disease
TMJ/ Clicking Joint

ALLERGIC TO: NONE
Any Metals (nickel, mercury)
Barbiturates
Codeine
Iodine
Latex Rubber
Local Anesthetics/Novocain
Penicillin/Other antibiotics
Sulfa Drugs
Other_____

Former Dentist _____ Phone Number _____Date last seen _____
Physician's Name_____ Phone Number _____Date last seen _____
Are you currently under medical treatment now? Yes / No Explain:_____
Medications Currently Taking (include non-prescription and birth control): _____
_____
Do you use tobacco? Yes / No

Authorization and Release

I hereby consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of dental procedures, x-rays, or other studies that the doctor orders. It is essential to the performance of good dentistry that the dentists have a full understanding of the physical well-being of the patient. Your cooperation in submitting this information is greatly appreciated, and will enable us to serve your particular needs with greater satisfaction. Of course, all information is confidential. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at the time of service, unless other arrangements are made.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination to me, or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (*or responsible party if patient is under the age of 18*)X_____Date_____