COKER FAMILY DENTISTRY

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**"You May Refuse to Sign This Acknowledgement"**

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

_____
(Please Print Name)

_____
(Signature)

_____
(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 acknowledgement
- Other (Please Specify)

_____

_____

_____

# Medical History Form

Date_____

Name_____ Home Phone (____)_____
Last First Middle

Address _____ Business Phone (____)_____
Number Street

City _____ State_____ Zip Code_____

Occupation _____ Social Security No._____

Date of Birth ____/____/____ Sex M F Height _____ Weight_____ Single_____ Married
Mo. Day Yr.

Name of Spouse _____ Closest Relative _____ Phone (____)_____

if you are completing this form for another person, what is your relationship to that person?_____

Referred by_____

**For the following questions, *circle yes* or *no*, whichever applies. your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.**

| | | | |
|---|---|---|---|
| 1. | Are you in good health? | Yes | No |
| 2. | Has there been any change in your general health within the past year? | Yes | No |
| 3. | My last physical examination was on_____ | Yes | No |
| 4. | Are you now under the care of a physician? | Yes | No |
| | If so, what is the condition being treated?_____ | | |
| 5. | The name and address of my physician(s) is _____ | | |
| | _____ | | |
| | _____ | | |
| 6. | Have you had any serious illness, operation, or been hospitalized in the past 5 years? | Yes | No |
| | If so, what was the illness or problem? | | |
| 7. | Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| | If so, what medicine(s) are you taking? | | |
| 8. | Do you have or have you had any of the following diseases or problems? | | |
| | a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease | Yes | No |
| | b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| | 1. Do you have chest pain upon exertion? | Yes | No |
| | 2. Do you have inborn heart defects? | Yes | No |
| | 3. Do you have a cardiac pacemaker? | Yes | No |
| | c. Sinus trouble | Yes | No |
| | d. Asthma or hay fever | Yes | No |
| | e. Fainting spells or seizures | Yes | No |
| | f. Diabetes | Yes | No |
| | g. Hepatitis, jaundice or liver disease | Yes | No |
| | h. AIDS or HIV infection | Yes | No |
| | i. Thyroid problems | Yes | No |
| | j. Respiratory problems, emphysema, bronchitis, etc. | Yes | No |
| | k. arthritis or painful swollen joints | Yes | No |
| | l. Stomach ulcer or hyperacidity | Yes | No |
| | m. Kidney trouble | Yes | No |
| | n. Tuberculosis | Yes | No |
| | o. Persistent cough or cough that produces blood | Yes | No |
| | p. Persistent swollen glands in neck | Yes | No |
| | q. Low blood pressure | Yes | No |
| | r. Sexually transmitted disease | Yes | No |
| | s. Epilepsy or other neurological disease | Yes | No |
| | t. Problems with mental health | Yes | No |
| | u. Cancer | Yes | No |
| | v. Problems of the immune system | Yes | No |
| | w. Knee or hip replacement/ any artificial joints | Yes | No |

9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No
12. Are you allergic or have you had a reaction to:
   a. LATEX ..... Yes No
   b. Local anesthetics ..... Yes No
   c. Penicillin or other antibiotics ..... Yes No
   d. Sulfa drugs ..... Yes No
   e. Barbiturates, sedatives, or sleeping pills ..... Yes No
   f. Aspirin ..... Yes No
   g. Iodine ..... Yes No
   h. Codeine or other narcotics ..... Yes No
   i. _____ Yes No
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain _____
   _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
   _____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No

Women

17. Are you pregnant? ..... Yes No
18. Are you nursing? ..... Yes No

**Chief Dental Complaint** _____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient

**Medical history update:**

| Date | Comments | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Date _____
first middle last

Patient's Birthdate _____ Age _____ Social Security Number _____ - _____ - _____

SINGLE_____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____

Home Address _____
street city state zip

Home Telephone _____ Work Telephone _____

Patient's Occupation _____ Shift Worked _____

Patient's Employer _____

Business Address _____
street city state zip

**PARENT-GUARDIAN OR SPOUSE'S INFORMATION**

Name _____
first middle last

Birthdate _____ Social Security Number _____ - _____ - _____

Occupation _____ Shift Worked _____

Employer _____ Work Telephone _____

Business Address _____
street city state zip

Alternate, Contact Person not living at same address

In case of an Emergency, please contact _____ Relationship _____

Home Phone _____ Work Phone _____

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

Who is responsible for this account? _____

## DENTAL INSURANCE

**PRIMARY COVERAGE**

Employee Name _____

Employer _____

Insurance Co. _____

Policy No. _____

Group No. _____

Insurance Co. Phone No. _____

Coverage: Family ( ) Individual ( )

**SECONDARY COVERAGE**

Employee Name _____

Employer _____

Insurance Co. _____

Policy No. _____

Group No. _____

Insurance Co. Phone No. _____

Coverage: Family ( ) Individual ( )

All accounts are due and payable when services are rendered. **Should payment not be made when due, the undersigned agrees to pay all costs of collection, including a reasonable attorney, and 1 1/2% interest on unpaid balance over 60 days.** The undersigned further waives as to his debt or any renewal thereof all rights of exemption under laws of Alabama and any other state, as to real or personal property. Further, the undersigned agrees that time for payment may be extended or other indulgence granted by Coker Family Dentistry, LLC but that any such action shall not constitute a waiver of any right by the said Coker Family Dentistry, LLC.

_____

Signature (responsible party if minor) Date

# Coker Family Dentistry Responsibility Statement

We would like to thank you for choosing Coker Family Dentistry. We strive to provide the highest quality dentistry in a timely manner. Our offices are open till 7:00 pm three days of the week for your convenience. In order for us to better serve you we have policies in place that we want you to know about and understand.

**BROKEN APPOINTMENT POLICY**

Due to the increase in patients seeking dental care, along with our effort to better serve our patients, we **require a 24-hour notice for any cancellation or rescheduling of your appointment.** This allows us to better serve other patients in need of treatment. **Any cancellation or rescheduling within 24 hours of your appointment will be considered a BROKEN APPOINTMENT.** Doctor's or Hygienist's Time has been set aside so that they can properly treat you and other patients. Therefore, we request that you are **on time** for your appointment so that we have plenty of time for you and our other patients while reducing wait time. Therefore, if you are late, we may have to reschedule your appointment, and it will be considered a **BROKEN APPOINTMENT**. We realize that events happen that could prevent our patients from following these policies, so we allow two broken appointments a year; however, after the third broken appointment **we will no longer be able to schedule the Doctor's or Hygienist's Time for you in Advance**.

**INSURANCE POLICY**

We at Coker Family Dentistry, L.L.C. are glad to file your insurance. If your insurance fails to pay within a reasonable period of time (normally 30 days), we will resubmit your claim. If insurance still fails to pay after the resubmission, we will bill the patient or guarantor accordingly and will expect payment from the patient or guarantor. It is the responsibility of the patient or guarantor to make any phone calls to the insurance company that may be necessary to prompt payment from them. It is also the patient or guarantor's responsibility to provide any additional information that the insurance company may request. Although we strive to ensure that all claims are sent correctly, occasionally there are errors in addresses, contract numbers, etc. These errors are usually corrected by a notice from the insurance company. However, some situations require help from the patient or guarantor due to missing or incorrect information given on the insurance paperwork. In the event of any error in filing an insurance claim, the patient or guarantor is not relieved of responsibility for payment of the account or for costs of collection, including finance charges and attorney's fees, etc. If no payment has been made on the account after a reasonable period of time, balances will be subject to finance charges of 1.5 per month; we reserve the right to take any and all necessary actions to collect on past due accounts, even if your insurance company has not paid. Please note: We are only required to file claims to those insurance companies with which we have **contracts. All other filing is done as a courtesy to the patient.**

I, THE UNDERSIGNED, have read the above responsibility statement, understand the broken appointment policy, and I agree to all of the terms given regarding the filing of my insurance, and that I am responsible for prompt payment of this account. I agree to pay amounts and charges incurred by myself or other patients on my account for services rendered at the time those services are rendered. I realize that failure to make payment when requested is basis for legal action, and I agree to pay all costs of collection, including finance charges and attorney's fees. I hereby waive my **rights of exemption under the laws of the State of Alabama and any other state.**

_____ Date _____

Guarantor's Signature

_____ Date _____

Witness