Coho Dental

Welcome! Please fill out the following information to the best of your ability.

New Patient Information

Patient Name: _____ Preferred: _____
Last First MI

☐ Male ☐ Female ☐ Other ☐ Married ☐ Single ☐ Dependent/Child

Birth Date: _____ Social Security #: _____-_____-_____

Phone (Home): _____ (Work): _____Ext: _____ (Cell): _____

E-Mail Address: _____

Do you prefer text or email reminders? ☐ Text ☐ Email

Home Address:

_____
Street City State Zip

Emergency Contact Name: _____
Emergency Contact Phone #: _____
Please list other members of your immediate family who are patients in our office, if applicable:

_____
_____
_____

Referral Information

Who may we thank for your referral to our office?

☐ I was referred by: _____ Relationship: _____
☐I found Coho Dental on my own. Source: _____
(Google, Insurance company, print ad, social media, etc.; please specify)

Appointment Policy

Please note that we require 24 hours' notice for appointment cancellations. Appointment changes without adequate notice may be subject to a fee of up to $70.00, payable by the patient and not the insurance company.

X Signature of Patient, Parent, or Guardian: _____ **Date:** _____

Insurance Information

Primary Insurance Policy

Name of Policy Holder: _____ Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth: _____ Policy Holder's ID#: _____Group #:

Policy Holder's Employer:_____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Dental Insurance Company Name: _____ Phone #: _____

Secondary Insurance Policy (if applicable)

Name of Policy Holder: _____ Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth:_____ Policy Holder's ID#: _____ Group #:_____

Policy Holder's Employer: _____

Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Dental Insurance Company Name:_____ Phone #: _____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company; however, you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefits: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Coho Dental of the insurance benefits otherwise payable to me.

X Signature of Patient, Parent, or Guardian: _____ Date: _____

Billing Policy, Consent for Treatment and Payment

Payment is expected at time of service. We accept cash, check, Visa, Discover, MasterCard and CareCredit. Aged balances over 60 days, regardless of insurance, are subject to their date of service(s) billing charge. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

X Signature of Patient, Parent, or Guardian: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, _____ , have received a copy of Coho Dental's Notice of Privacy Practices and consent to the healthcare operations it describes.

Print the Name of the Patient or Personal Representative:

_____

Please list individuals with whom you authorize us to share your medical and dental information, including: charts, treatment notes, radiographs and other images, insurance and financial statements, and other communications (if any):

_____

_____

_____

_____

X Signature of Patient or Personal Representative: _____

Relationship to Patient: _____

Date: _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _ _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Coho Dental

Informed Consent for Routine Dental Care

Informed Consent and Patient Education

As a rule, excellent dental results can be achieved with informed and cooperative patients. It is our goal for every patient to feel that they have been educated about the benefits and risks of recommended treatments to their satisfaction. Recognizing the benefits of a pleasing smile and healthy teeth, patients should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contraindicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is Our Goal

Perfection is always our goal. However, because we treat the human body, factors such as developmental deficiencies, the consequences of dental disease, genetics and/or anatomy, and patient health status or cooperation level may prevent the attainment of a "perfect" result. At times, a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to ensure the best possible care for each patient's unique situation.

The Importance of Regular Maintenance

Throughout life, teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and daily plaque removal is a must.

Complications of Receiving Local Anesthetic Injection

Local anesthetic is regularly administered with a very low rate of complications. Local anesthetic makes many of the treatments we perform possible and comfortable for our patients. However, complications may occur and include: allergic reaction, and damage to nerves, blood vessels, or muscle fibers. Damage to anatomic structures may result in temporary or permanent loss of sensation, altered taste or sensation, swelling or bruising, limited jaw opening or jaw soreness. Please inform your dentist if you have a local anesthetic allergy or if you have had complications from receiving local anesthetic in the past.

Complications of Dental Prophylaxis and Scaling

After receiving a dental cleaning, you may experience increased thermal sensitivity or gum soreness for a time. This usually improves over the course of a few days to weeks and is greatly expedited by

continuing a good oral hygiene regimen at home. Dental restorations such as fillings, crowns, or wire retainers that are correctly bonded should not become dislodged during routine or deep cleanings. Sometimes, restorations that have formed small decay or lost their bond to the tooth become easily dislodged with gentle pressure. If this occurs, your dental restoration will have to be replaced or re-bonded in order to protect the tooth/teeth involved.

Complications of Decay Removal and Restoration with Fillings or Crowns

Sometimes a tooth that appears minimally decayed from the exterior will in fact have large, deep decay. When this happens, the treatment plan can change from a filling or crown to a root canal or even an extraction. This is especially true when the tooth has existing restorations that have already resulted in the loss of tooth structure.

Sensitivity of a tooth treated with fillings or crowns may occur and usually dissipates with the passing of time. If the sensitivity worsens or doesn't seem to improve in a few weeks, a root canal treatment may be necessary. A tooth that has been damaged by deep decay, trauma, or extensive dental treatment can take up bacterial toxins and die over a long period of time. An undetected non-vital tooth may flare up unexpectedly and require endodontics (root canal) treatment to maintain. In some situations, it is better to remove the tooth than to continue to try to save it.

Although rare, it is possible that a dental instrument or bur will break while being used inside your mouth. If this happens, the quick action of an assistant with high volume suction can retrieve the fragment. On rare occasion, the fragment may imbed and need to be retrieved surgically. If the fragment cannot be found it may have been swallowed or aspirated and a chest x-ray will be necessary to rule out aspiration (breathing the fragment into the lung, which can have severe consequences).

There is also a risk that during or following treatment, soreness or tenderness may occur in the temporomandibular (jaw) joints, gum tissue, tongue, cheek, or lips. Following post-operative instructions will aid in proper healing and minimizing potential complications.

Specialty Procedures

Some special procedures, namely Tooth Extraction, Crown or Bridge Treatments, Implant Placement, Orthodontic Clear Aligners, and Root Canal Treatment, have their own special consent forms with which you will be presented if applicable.

Informed Consent for Routine Dental Cleanings and Treatment including Fillings

I understand that during treatment occasionally any of the above problems may occur.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following actions are essential on my part:

1. Excellent oral hygiene

2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification, who are repeatedly late for appointments, who fail to practice acceptable oral hygiene, or who are uncooperative or unkind with team members providing care.

Patient Signature: _____

Date: _____

Coho Dental

HIPAA Notice

Notice of Patient's Rights and Office Policies Concerning Protected Health Information

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS OF THE UTMOST IMPORTANCE TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect Jan 1st, 2023, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it

was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS Please review your rights as a patient in our office regarding your own access to and control over your dental records.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of

this Notice. If you request copies, we will charge you $25.00. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer

Dr. Cody Holt
Telephone: 907-349-4343
E-mail: admin@holtdds.com