Coco Dental

12835 Preston RD STE 217
Dallas, TX 7230

Date_____/_____/_____

Patient Information:

First Name_____ Last Name_____

Address_____ City_____ State____ Zip_____

Home Phone:(____) _____-_____ Work Phone:(____) _____-_____ Cell Phone:(____) _____-_____

Date of Birth_____/_____/_____ Age: _____ Social Security #_____-_____-_____

Sex _____ Marital Status _____ Driver's License_____ State_____

Employer _____ Phone # (_____) _____-_____

E- Mail _____

Account information

Responsible Party (If different than above):

First Name_____ M.I. ____ Last Name_____

Address_____ City_____ State____ Zip_____

Home Phone:(____) _____-_____ Work Phone:(____) _____-_____ Cell Phone:(____) _____-_____

Date of Birth_____/_____/_____ Age: _____ Social Security #_____-_____-_____

Sex _____ Marital Status _____ Driver's License_____ State_____

Employer _____ Phone # (_____) _____-_____

Insurance information

Insurance Co_____Phone:(____) _____-_____

Subscriber Name_____ M.I._____ Last Name_____

Subscriber I.D. _____Group Name _____Group # _____

Social Security #_____-___-_____ Date of Birth____-____-____ Driver's License #_____

Who should we contact in the unlikely event of an emergency?

Name_____ Relationship to patient_____

Home Phone:(____) _____-_____ Work Phone:(____) _____-_____ Cell Phone:(____) _____-_____

Who may we thank for referring you to our practice? _____

Medical History Form

Last Name _____ First Name _____ M.I. _____

❑No ❑Yes Are you currently under the care of a physician?
If yes for what reason:_____

❑No ❑Yes Have you ever been hospitalized?
If yes please explain: _____

❑No ❑Yes Are you taking any prescription medications?
If yes, please explain: _____

❑No ❑Yes Are you taking any over the counter medications?
If yes, please explain: _____

❑No ❑Yes Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?
If yes, please explain: _____

❑No ❑Yes Are you allergic to any medications or substances?
If yes, please explain: _____

❑No ❑Yes Do you have any problems with antibiotics or anesthetics?
If yes, please explain:_____

❑No ❑Yes Do you take appetite suppressants? If yes, name of product: _____

Have you ever had any of the following diseases or medical conditions?

❑No	❑Yes	Heart Attack/Stroke	❑No	❑Yes	Epilepsy
❑No	❑Yes	Cancer/Chemotherapy	❑No	❑Yes	Seizures
❑No	❑Yes	Heart Murmur	❑No	❑Yes	Fainting
❑No	❑Yes	Rheumatic Fever	❑No	❑Yes	Diabetes
❑No	❑Yes	HIV/AIDS	❑No	❑Yes	Tuberculosis
❑No	❑Yes	Hepatitis A	❑No	❑Yes	Hemophilia
❑No	❑Yes	Hepatitis B	❑No	❑Yes	Blood Transfusion
❑No	❑Yes	Hepatitis C	❑No	❑Yes	High Blood Pressure
❑No	❑Yes	Hepatitis D	❑No	❑Yes	Low Blood Pressure
❑No	❑Yes	Anemia	❑No	❑Yes	Radiation Treatment
❑No	❑Yes	Mitral Valve Prolapse	❑No	❑Yes	Kidney Problems
❑No	❑Yes	Artificial Bones/Joints	❑No	❑Yes	Artificial Valves
❑No	❑Yes	Sinus Problems	❑No	❑Yes	Severe Headaches
❑No	❑Yes	Difficulty Breathing	❑No	❑Yes	Frequent Headaches
❑No	❑Yes	Venereal Disease	❑No	❑Yes	Emphysema
❑No	❑Yes	Herpes Type I	❑No	❑Yes	Herpes Type II
❑No	❑Yes	Heart Surgery	❑No	❑Yes	Pace Maker
❑No	❑Yes	Psychiatric Problems	❑No	❑Yes	Glaucoma
❑No	❑Yes	Do you smoke?	❑No	❑Yes	Do you consume alcohol?

For Women Only:

❑No	❑Yes	Taking Birth Control Pills	❑No	❑Yes	Pregnant/No. of months:_____
❑No	❑Yes	Nursing	❑No	❑Yes	Hormone Therapy

Are you allergic to any of the following?

❑No	❑Yes	Penicillin	❑No	❑Yes	Codeine
❑No	❑Yes	Aspirin	❑No	❑Yes	Tetracycline
❑No	❑Yes	Erythromycin	❑No	❑Yes	Germicides/Pesticides
❑No	❑Yes	Latex/or Rubber Products	❑No	❑Yes	Other_____

Signature_____ Date_____

Coco Dental

3450 Forest Ln. Dallas, Tx. 75234

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: _____

We may call or write to remind you to scheduled appointments, it is time to make a routine appointment. We may also call or write to notify you of other treatments services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

I authorize Coco Dental Office to release health information identifying me (including if applicable, information about HIV infections or AIDS, information about substance abuse treatment, and information about mental health services) to carry out treatment, payment and dental procedures.

The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us written or electronic note telling us that your authorization is revoked.

Notice of Privacy Practices

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

-The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care services; or getting copies of your health information from another professional that you may have seen before us.

Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of ours records. We routinely use your health information inside our office for these purposes without any special permission.

You may refer to Coco Dental's notice of privacy practices for more complete description.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIFNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____ Date _____