Benjamin Cooperman, D.D.S.
25101 N. Lake Pleasant Parkway
Suite B-1335, Peoria, AZ 85383

Thank You for Selecting Dr. Cooperman

New Patient Information (Confidential)

Date: _____

Patient Name:_____

Birthdate_____Age_____ Sex (M)___(F) ___SS # _____

Street Address_____

City_____ State_____ Zip Code _____

Parent/Guardian Address (If different)_____

Phone #_____ Cell # _____

Email _____

Whom may we thank for referring you?_____

How should we remind you of appointments? Call _____Email_____ Text _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone #_____ Cell # _____

INSURANCE INFORMATION

Insurance Company _____ Phone #_____

ID#_____ Group # _____

Subscriber Name (if different from Patient) _____

Birthdate_____ SS Number_____ Relationship to Patient _____

Ins. Co. Address_____City_____State_____Zip_____

SECONDARY INSURANCE

Insurance Company _____ Phone #_____

ID#_____ Group # _____

Subscriber Name (if different from Patient) _____

Birthdate_____ SS Number_____ Relationship to Patient _____

Ins. Co. Address_____City_____State_____Zip_____

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PATIENT MEDICAL HISTORY

Patient name: _____

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last 3 years? If yes, why?
   _____
4. Yes No Are you being treated by a Physician now? For what? _____
5. Date of last medical exam? _____ Physician's contact info:_____
6. Date of last dental exam? _____ _____
7. Yes No Have you had problems with prior dental treatment? Describe:_____
8. Yes No Are you in pain now?
9. Yes No Have you ever had orthodontic treatment? If so, when? _____
10. Are you taking (circle all that apply Tobacco in any form, Alcohol, Recreational Drug, Drugs, medications, over-the-counter medicines (including aspirin), natural remedies? Please list:_____
    _____
11. **WOMEN ONLY**: Are you or could you be pregnant or nursing? Please Do Explain:_____
12. Do you have any other diseases or medical problems NOT listed on this form? If so, please explain:
    _____

HAVE YOU EXPERIENCED:

1.	Yes	No	Chest pain (angina)?	12.	Yes	No	Dizziness?
2.	Yes	No	Swollen ankles?	13.	Yes	No	Ringing in ears?
3.	Yes	No	Shortness of breath?	14.	Yes	No	Headaches?
4.	Yes	No	Recent weight loss, fever, sweats?	15.	Yes	No	Fainting spells?
5.	Yes	No	Persistent cough, coughing blood?	16.	Yes	No	Blurred vision?
6.	Yes	No	Bleeding problems, bruise easily?	17.	Yes	No	Seizures?
7.	Yes	No	Sinus problems?	18.	Yes	No	Excessive thirst?
8.	Yes	No	Difficulty swallowing?	19.	Yes	No	Frequent urine?
9.	Yes	No	Diarrhea, constipation, bloody stool?	20	Yes	No	Dry Mouth?
10.	Yes	No	Frequent vomiting, nausea?	21.	Yes	No	Jaundice?
11.	Yes	No	Difficulty urinating, blood in urine?	22.	Yes	No	Joint pain

DO YOU OR HAVE YOU HAD:

1.	Yes	No	Heart Disease, Attacks, Defects, Murmur	13.	Yes	No	HIV?
2.	Yes	No	Pacemaker	14.	Yes	No	AIDS?
3.	Yes	No	Rheumatic fever?	15.	Yes	No	Eye diseases?
4.	Yes	No	Stroke, hardening of arteries	16.	Yes	No	Skin diseases?
5.	Yes	No	High Blood Pressure	17.	Yes	No	Anemia?
6.	Yes	No	Asthma, TB, Emphysema, other lung diseases?	18.	Yes	No	Venereal Disease?
7.	Yes	No	Hepatitis, other liver disease?	19.	Yes	No	Herpes?
8.	Yes	No	Stomach problems, ulcers?	20.	Yes	No	Kidney, bladder disease?
9.	Yes	No	Psychiatric care?	21.	Yes	No	Hospitalization?
10.	Yes	No	Prosthetic heart valve?	22.	Yes	No	Blood transfusion?
11.	Yes	No	Artificial joints?	23.	Yes	No	Respiratory Problems?
12.	Yes	No	Contact lenses?	24.	Yes	No	Gout
13.	Yes	No	Mitral Valve Prolapse?	25.	Yes	No	Thyroid, adrenal disease?

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Are you allergic to or have you had any reactions to the following: Local Anesthetics (e.g. novocain) _____ Penicillin or any other Antibiotics_____ Sulfa Drugs_____ Barbiturates_____ Sedatives_____ Iodine_____Aspirin_____ Drugs_____ Foods_____ Medications_____ Latex_____

Any metals (e.g. nickel, mercury, etc.)_____

Please list other allergies: _____
_____

FAMILY HISTORY:

Yes	No	Tumors	Yes	No	Cancer
Yes	No	Arthritis	Yes	No	Diabetes
Yes	No	Heart attacks	Yes	No	Low Blood Pressure
Yes	No	High Blood Pressure			

Any other family history? Please list:
_____

Have you had to be premedicated prior to dental treatment? Yes_____ No _____

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

IMPORTANT MEDICAL ALERT

A connection between FOSAMAX and other bisphosphonates, with serious bone disease called Osteonecrosis of the Jaw (ONJ) has been found. BISPHOSPHONATES are commonly used in tablet form to prevent and treat osteoporosis in postmenopausal women, and older men. They are also used in the treatment of Paget's Disease. Stronger forms given orally or intravenously (I.V.) are commonly used in the management of advanced cancers including, but not limited to, lung cancer, breast cancer, prostate cancer, multiple myeloma and other metastatic cancers.

Have you **EVER** taken of of the following oral medications:

Yes	No	Alendronate (Fosamax Plus)	Yes	No	Zoledronate (Zometa)
Yes	No	Clodronate (Bonefos, Ostac)	Yes	No	Pamidronate (Aredia)
Yes	No	Etidronate (Didronel)	Yes	No	Clodronate (Bonefos)
Yes	No	Ibandronate (Boniva)	Yes	No	Tiludronate (Skelid)
Yes	No	Pamidronate (Aredia)	Yes	No	Risedronate (Actonel)
Yes	No	Zoledronate (Zometra, Reclast) Annual Infusion			
Yes	No	Have you EVER been treated for cancer with chemotherapy?			

If yes, when?_____Prescribing Doctor Name _____
Doctor's Phone Number_____

AUTHORIZATION AND RELEASE

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 understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forty above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action taken or not taken because of errors or omissions that I may have made in the completion of this form.

Patient Signature_____Print Name_____Date_____

Doctor's Signature_____Date_____

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PATIENT DENTAL HISTORY

Patients name: _____
Name of Previous Dentist_____

1. Yes No Do your gums bleed while brushing or flossing?
2. Yes No Are your teeth sensitive to hot or cold liquids/foods?
3. Yes No Do you have any sores or lumps in or near your mouth?
4. Yes No Have you had any head, neck or jaw injuries?
5. Yes No Have you ever experienced any of the following problems in your jaw?
6. Yes No Clicking
7. Yes No Difficulty in opening or closing
8. Yes No Difficulty in chewing
9. Yes No Do you have frequent headaches?
10. Yes No Do you clench or grind your teeth?
11. Yes No Do you bite your lips or cheeks frequently?
12. Yes No Have you ever had any difficult extractions in the past?
13. Yes No Have you ever had any prolonged bleeding following extractions?
14. Yes No Do you wear dentures or partials? If Yes, date of placement _____
15. Yes No Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
16. Yes No Do you like your smile?
17. Yes No Are you interested in whitening?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

***You May Refuse to Sign This Acknowledgment**

I, _____, have read a copy of this office's Notice of Privacy Practices. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use of my personal health information.

_____ _____ _____

Print Name **Signature** **Date**

FOR OFFICIAL 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

_____ Communication barrier prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other: _____

Staff Member Signature: _____ Date _____

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HIPAA RELEASE & DISCLOSURE AGREEMENT

Name: _____ Date of Birth: ____/____/____

We are unable to discuss your treatment with anyone unless you give us written permission.

Please select your preferences below with an X:

I authorize the release of information including the diagnosis, records, images, treatment rendered to me and account and claims information. This information may be released to the following: *Please note: Certain treatments may require the patient to be sedated. You will need to have a driver. Your driver must be listed on this medical information release form prior to treatment.*

My general and/or referring dentist: _____
Spouse name:_____
Children(s) name(s): _____
Parent name: _____
Other name: _____
Information is not to be released to anyone: _____

The release of information will remain in effect until terminated by me in writing.

Patient Signature _____ Date ___/___/___

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FINANCIAL POLICY

Our Doctors & staff are very concerned about the cost of your dental needs & would like to address some current issues related to the cost of dental services in this office. Considerable care has been taken in setting up our fee schedule. We would like to assure you that the charges accurately reflect the skill & expertise required as well as quality of materials used to provide the best service for you. Our fees are comparable with fees of other dentists in the area that provide similar quality care.

If any insurance company indicates that our fees are above the "Usual & Customary", please understand that most dentist fees are above the rate which insurance companies choose to pay. We cannot and do not allow insurance companies to set or dictate fees or service we provide our patients. Our policy requires payment at time of service. As always, we do accept Visa, MasterCard, American Express and Discover.

If you have insurance you must pay your estimated portion at the time of service. As a courtesy we will file the claim with your insurance carrier. However, our agreement for payment is with you and NOT your insurance company. Payment to our office is neither contingent nor dependent upon your insurance.

There is a $25.00 service charge for all returned checks. There will be interest charged if your account becomes delinquent beyond 30 days. You understand that if you default on your payments, an outside collection agency will be used. You understand that you will be responsible for the collection fees of 45% of the outstanding balance. You also understand should a suit be brought against you, you will be responsible for court costs and attorney fees.

I understand and accept that a 24-hr notice of cancellation is necessary to avoid a charge of $50.00 for every hour that was scheduled for my treatment. In the event of 2 missed appointments with less than a 24 hour notice, Dental Ben's has the right to dismiss you from the practice.

_____ _____ Signature of Responsible

Party Date

Benjamin Cooperman, D.D.S.
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RECORDS RELEASE REQUEST

Date: _____

To: _____

Previous Doctor Name

Address: _____

City: _____ State _____ Zip Code_____

Phone:_____ Fax:_____

I authorize the release of my dental records or copies of such, and request that they be transferred to:

Dr. Benjamin Cooperman
25101 N. Lake Pleasant Pkwy. Suite 1335
Peoria, AZ 85383
Telephone: 623-289-9334
Email: info@dentalbens.com

_____ _____

Printed Name of Patient Date of birth

_____ _____

Signed name of patient Date