

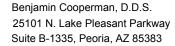
# Thank You for Selecting Dr. Cooperman New Patient Information (Confidential)

| Date:                  |                                    |         |                       |        |
|------------------------|------------------------------------|---------|-----------------------|--------|
| Patient Name:          |                                    |         |                       |        |
| Birthdate              | Age                                | Sex (   | M)(F)SS # _           |        |
| Street Address         |                                    |         |                       |        |
| City                   | Stat                               | :e      | Zip Code _            |        |
| Parent/Guardian Addr   | ess (If different)                 |         |                       |        |
| Phone #                | Ce                                 | II #    |                       |        |
| Email                  |                                    |         |                       |        |
| Whom may we thank f    | or referring you?                  |         |                       |        |
| How should we remine   | d you of appointment               | s? Call | Email                 | _ Text |
|                        |                                    |         |                       |        |
| EMERGENCY CONTA        | СТ                                 |         |                       |        |
| Name                   |                                    | Relatio | nship                 |        |
| Phone #                |                                    | Cell #  |                       |        |
|                        |                                    |         |                       |        |
| INSURANCE INFORM       | IATION                             |         |                       |        |
| Insurance Company _    |                                    |         | Phone #               |        |
| ID#                    |                                    | Group   | #                     |        |
| Subscriber Name (if di | fferent from Patient) _            |         |                       |        |
| Birthdate              | SS Number                          | R       | elationship to Patier | ıt     |
| Ins. Co. Address       |                                    | _City   | State                 | Zip    |
|                        |                                    |         |                       |        |
| SECONDARY INSURA       | ANCE                               |         |                       |        |
| Insurance Company _    |                                    |         | Phone #               |        |
| ID#                    |                                    | Group   | #                     |        |
| Subscriber Name (if di | fferent from Patient) <sub>-</sub> |         |                       |        |
| Birthdate              | SS Number                          | R       | elationship to Patier | t      |
| Ins. Co. Address       |                                    | _City   | State                 | Zip    |



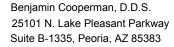
### **PATIENT MEDICAL HISTORY**

| Patient            | name | :       |   |  |          |                                     |  |  |
|--------------------|------|---------|---|--|----------|-------------------------------------|--|--|
| 1.                 | Yes  | No      | Is your general health good?                                  |  |          |                                     |  |  |
| 2.                 | Yes  | No      | Has there been a change in your health within the las         | s there been a change in your health within the last year? |          |                                     |  |  |
| 3.                 | Yes  | No      | Have you been hospitalized or had a serious illness in        | If yes, why?   |          |                                     |  |  |
| 4.                 |      |         | Are you being treated by a Physician now? For what?           |  |          |                                     |  |  |
| 5.                 | Date | of last |   |  |          |                                     |  |  |
| 6.<br><del>-</del> |      | of last | dental exam?  |  |          |                                     |  |  |
| 7.                 | Yes  |         | Have you had problems with prior dental treatment? [          | Describe:  |          |                                     |  |  |
| 8.                 | Yes  |         | Are you in pain now?  | 2  |          |                                     |  |  |
| 9.                 | Yes  |         | Have you ever had orthodontic treatment? If so, when          |  |          |                                     |  |  |
| 10.                |      |         | ng (circle all that apply Tobacco in any form, Alcohol,       | Recreational   | Drug, I  | Drugs, medications, over-the-counte |  |  |
|                    |      |         | ncluding aspirin), natural remedies? Please                   |  |          |                                     |  |  |
| 11                 | WON  | JEN ON  | <b>NLY</b> : Are you or could you be pregnant or nursing? Ple | ase Do Evol  | ain·     |                                     |  |  |
|                    |      |         | e any other diseases or medical problems NOT listed           |  |          |                                     |  |  |
| 12.                | БО у | ou nave | e any other diseases of medical problems NOT listed           | on this form:  | 11 30, 1 | леазе ехрапт.                       |  |  |
|                    |      |         |   |  |          | _                                   |  |  |
| HAVE Y             | OU E | XPERIE  | ENCED:  |  |          |                                     |  |  |
| 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 YO              | U OR | HAVE \  | OU 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.                |      | 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  |          | Gout                                |  |  |
| 13.                |      | No      | Mitral Valve Prolapse?  | 25. Yes  |          |                                     |  |  |





|                                    |                                     | or have you had any re  |  |                            |                              |                         |                          |                                     |  |
|------------------------------------|-------------------------------------|---|--|----------------------------|------------------------------|-------------------------|--------------------------|-------------------------------------|--|
|                                    |                                     | Sulfa Drugs   |  |                            |                              | _ Sedativ               | es                       | lodine                              | Aspirin  |
| Drugs                              | Food                                | ls Medications  | Latex  |                            |                              |                         |                          |                                     |  |
| Any meta                           | ls (e.g. n                          | ickel, mercury, etc.)   |  | -                          |                              |                         |                          |                                     |  |
| Please list                        | t other a                           | llergies:   |  |                            |                              |                         |                          |                                     |  |
| FAMILY H                           | IISTORY                             | :   |  |                            |                              |                         |                          |                                     |  |
| `                                  | Yes No                              | Tumors  |  |                            | Yes                          | No                      | Cance                    |                                     |  |
|                                    | Yes No                              |   |  |                            | Yes                          | No                      | Diabet                   |                                     |  |
|                                    | Yes No                              |   |  |                            | Yes                          | No                      | Low B                    | lood Pressure                       |  |
| `                                  | Yes No                              | High Blood Pres   | sure   |                            |                              |                         |                          |                                     |  |
| Δ                                  | any othe                            | r family history? Please I  | ist:   |                            |                              |                         |                          |                                     |  |
| Have you                           | had to                              | be premedicated prior t   | o dental treatment? Y  | ⁄es                        |                              |                         | No                       |                                     |  |
| Note: Bot                          | h Docto                             | and patient are encour  | aged to discuss any ar   | nd all                     | releva                       | nt patient              | t health is              | sues prior to tr                    | eatment.                                       |
| IMPORTA                            | NT ME                               | DICAL ALERT   |  |                            |                              |                         |                          |                                     |  |
| has been<br>women, a<br>are comm   | found. E<br>nd olde<br>ionly use    | veen FOSAMAX and oth<br>SISPHOSPHONATES are<br>men. They are also use<br>ed in the management o<br>yeloma and other metas | commonly used in tak<br>d in the treatment of F<br>f advanced cancers in     | olet fo<br>Paget'          | rm to p<br>s Disea           | orevent a<br>ase. Stroi | ind treat o              | osteoporosis in<br>s given orally o | postmenopausal or intravenously (I.V.)         |
| Have you                           | EVER to                             | aken of of the following o  | oral medications:  |                            |                              |                         |                          |                                     |  |
|                                    |                                     | onate (Fosamax Plus)  | Yes  | No                         | Zoled                        | dronate (Z              | Zometa)                  |                                     |  |
| Yes No                             | Clodro                              | nate (Bonefos, Ostac)   | Yes  | No                         | Pamio                        | dronate (A              | Aredia)                  |                                     |  |
|                                    |                                     | nate (Didronel)   | Yes  |                            |                              | onate (Bo               |                          |                                     |  |
|                                    |                                     | onate (Boniva)  | Yes  |                            |                              | onate (S                | ,                        |                                     |  |
|                                    |                                     | onate (Aredia)  | Yes  | No                         | Rised                        | ronate (A               | ctonel)                  |                                     |  |
|                                    |                                     | onate (Zometra, Reclast)<br>ou EVER been treated f  |  | herap                      | y?                           |                         |                          |                                     |  |
| If yes, who                        |                                     | Prescri<br>umber  | bing Doctor Name   |                            |                              |                         |                          |                                     |  |
| AUTHOR                             | IZATION                             | AND RELEASE   |  |                            |                              |                         |                          |                                     |  |
| accurately informatic satisfaction | y answe<br>on for tre<br>on. I will | e read and understand the imating me. I acknowledge not hold my dentist, or a cons that I may have made                   | portance of a truthful I<br>e that my questions, if<br>iny other member of h | health<br>any, a<br>is/her | histor<br>about i<br>staff r | y and the               | at my den<br>set forty a | tist and his/her<br>above have be   | r staff will rely on this<br>en answered to my |
| Patient Si                         | ignature                            |   | Print Name   |                            |                              |                         | Date                     | ·                                   |  |
| Doctor's                           | Signatu                             | re  |  |                            |                              |                         | Date                     |                                     |  |





Patients name: \_\_\_

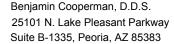
### PATIENT DENTAL HISTORY

| Name o   | of Pre                                  | vious  | s Dentist   |  |
|--|---|--|---|--|
| 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9. | Yes | No<br>No<br>No<br>No<br>No<br>No<br>No<br>No | Do your gums bleed while brushing or flossing? Are your teeth sensitive to hot or cold liquids/foods? Do you have any sores or lumps in or near your mouth? Have you had any head, neck or jaw injuries? Have you ever experienced any of the following problems Clicking Difficulty in opening or closing Difficulty in chewing Do you have frequent headaches? Do you clench or grind your teeth? Do you bite your lips or cheeks frequently? | s in your jaw?                                     |
|  |   |  | Have you ever had any difficult extractions in the past?  |  |
|  |   |  | Have you ever had any prolonged bleeding following extr   | actions?   |
|  |   |  | Do you wear dentures or partials? If Yes, date of placemer  |  |
|  |   |  | Have you ever received oral hygiene instructions regarding  | ng the care of your teeth and gums?                |
|  |   |  | Do you like your smile?   |  |
| 17.  | Yes                                     | No   | Are you interested in whitening?  |  |
|  |   |  | ACKNOWLEDGEMENT OF RECEIPT OF NOTICE *You May Refuse to Sign This Ack   |  |
| I,   |   |  | , have read a copy  | of this office's Notice of Privacy Practices. I    |
|  |   |  | may ask for a copy to take with me at any time, and that an   |  |
|  |   |  |   |  |
| questio  | ns tna                                  | at i m                                       | nay have now, or in the future, regarding the use of my pers  | onal nealth information.                           |
| Print N  | ame                                     |  | Signature   | Date   |
|  |   |  | FOR OFFICIAL USE ON   | LY   |
| We atte  | mpte                                    | d to   | obtain written acknowledgement of receipt of our Notice of  | F Privacy Practices, but acknowledgement could not |
| be obta  | ined                                    | beca   | use:  |  |
| In   | ıdividı                                 | ual re                                       | efused to sign  |  |
| c  | ommı                                    | unica  | tion barrier prohibited obtaining acknowledgement   |  |
| A  | n eme                                   | erger  | ncy situation prevented us from obtaining acknowledgment  |  |
| 0  | ther:                                   |  |   |  |
| Staff Me   | embe                                    | r Sig  | nature: Date  | _  |
|  |   |  |   |  |



# **HIPAA RELEASE & DISCLOSURE AGREEMENT**

| Name:   | _ Date of Birth:/  |
|---|--|
| We are unable to discuss your treatment with anyone unle    | ss you give us written permission.   |
| Please select your preferences below with an X:             |  |
| claims information. This information may be released to the | sis, records, images, treatment rendered to me and account and<br>e following: Please note: Certain treatments may require the<br>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 term | ninated by me in writing.  |
| Patient Signature   | _ Date/  |





#### **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 |                          |



# **RECORDS RELEASE REQUEST**

| Date:                          | _                                       |   |    |  |  |
|--------------------------------|---|---|----|--|--|
|                                |   |   |    |  |  |
| То:                            |   |   | _  |  |  |
|                                |   | Previous Doctor Name  |    |  |  |
|                                |   |   |    |  |  |
| Address:                       |   |   | -  |  |  |
| City:                          | _ State                                 | Zip Code  |    |  |  |
| Phone:                         | Fax:                                    |   | _  |  |  |
| authorize the release of my de |   | es of such, and request that they be transferred to<br>Benjamin Cooperman | ): |  |  |
|                                | 25101 N. Lake Pleasant Pkwy. Suite 1335 |   |    |  |  |
|                                |   | Peoria, AZ 85383  |    |  |  |
|                                | Tele                                    | ephone: 623-289-9334  |    |  |  |
|                                | Ema                                     | il: <u>info@dentalbens.com</u>  |    |  |  |
|                                |   |   |    |  |  |
| Printed Name of Patient        |   | Date of birth   |    |  |  |
| Signed name of patient         |   |   |    |  |  |
|                                |   |   |    |  |  |