Howard F. Cooke, D.M.D., M.S.

MEDICAL HISTORY FORM

Patient Name _____ **Today's Date** _____

Date of Birth_____ Age: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
6. Have you had any serious illness, operation or hospitalization within the past 10 years? ..... Yes No
   _____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
   b. Rheumatic Heart Disease ..... Yes No
   c. Heart trouble ..... Yes No
      1. Heart attack ..... Yes No
      2. Angina ..... Yes No
      3. High blood pressure ..... Yes No
      4. Stroke ..... Yes No
      5. Arteriosclerosis ..... Yes No

      or any other heart condition including pacemaker or defibrillator ..... Yes No
      1. Chest pain upon exertion? ..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
   d. Allergies ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Fainting spells or seizures ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice or liver disease ..... Yes No
   j. Frequent or recurring mouth sores ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, COPD, etc. ..... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
   n. Osteoporosis ..... Yes No
   o. Stomach ulcer or hyperacidity ..... Yes No
   p. Kidney trouble ..... Yes No
   q. Tuberculosis ..... Yes No

Patient Name: _____ Today's Date: _____

r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system..... Yes No
x. Anxiety, Depression or any other mental disorder..... Yes No

10. Have you had abnormal bleeding?..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
11. Do you have any blood disorder such as anemia? ..... Yes No
12. Have you ever had treatment for a tumor or growth? ..... Yes No
13. Have you had radiation therapy to the head, neck or jaws?..... Yes No
14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain:_____
    _____
15. Do you have any other condition or disease you think the doctor should know about?..... Yes No
    If so, explain:_____
16. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
17. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you? ..... Yes No
18. Do you have sleep apnea or use/have you ever used a c-pap machine..... Yes No
19. Are you wearing removable dental appliances? ..... Yes No
20. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

21. Are you pregnant or trying to become pregnant ..... Yes No
22. Do you have problems associated with your menstrual period? ..... Yes No
23. Are you nursing?..... Yes No
24. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint: _____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

_____

Patient Signature/Date

Patient Name: _____ Today's Date: _____

MEDICATIONS: Are you allergic to, sensitive to, or had a bad reaction to: (Circle Yes or No)

Local Anesthetic (Novocaine, etc.)	Yes	No	Aspirin/Ibuprofen	Yes	No
Penicillin/Amoxicillin	Yes	No	Codeine	Yes	No
Latex/Rubber Products	Yes	No	Sulfa	Yes	No
Barbiturates/Sedatives	Yes	No	Eggs	Yes	No

List any other medications you are allergic to: _____

_____

_____

_____

ARE YOU USING OR TAKING ANY OF THE FOLLOWING? (Circle Yes or No)

Tagamet	Yes	No	Other Heart Medicine _____	Yes	No
Antibiotics or Sulfa Drugs	Yes	No	Fosamax, Boniva or Actonel	Yes	No
High Blood Pressure Medications	Yes	No	Thyroid Medications	Yes	No
Tranquilizers (Valium, Anti-Depressants)	Yes	No	Anticoagulants (Blood Thinners)	Yes	No
Antihistamines or Decongestants (Seldane)	Yes	No	Steroids (Cortisone, etc.)	Yes	No
Aspirin or Ibuprofen (Motrin, Naprosyn, etc.)	Yes	No	Insulin, Diabetes, Similar Drugs	Yes	No
Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia	Yes	No	Weight Loss Medications If yes, how much daily? _____	Yes	No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescriptions and over-the-counter medications (i.e. aspirins, antacids), herbal supplements (i.e. ginseng, gingko). Include all medications taken as needed (i.e. nitroglycerin, inhalers, and allergy medications).

Name of Medication	Dosage / amount	When do you take it?	Purpose of Medication	

Howard F. Cooke, D.M.D., M.S.
Diplomate, American Board of Oral and Maxillofacial Surgery

WELCOME TO OUR PRACTICE!

Patient's First Name _____MI _____ Last Name_____

According HIPPA Compliance please circle whether or not we may leave a detailed message at each number provided.

Phone: Mobile(___)___-____(Y/N) Work:(___)___-_____(Y/N) Home: (___)___-_____(Y/N)

Email Address: _____ May we correspond by email? Circle one Y/N

Sex: M ❑ F ❑ Date of Birth: __/__/____ Age:__ SS#:___-__-____ DL#:_____

Address _____Apt:_____ City:_____ State:__ Zip:_____

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Employed: ❑Full Time ❑Part Time ❑Retired ❑Student

Medical Doctor _____ Dentist:_____

Orthodontist _____

Emergency Contact Name _____Number_____

Dental Ins Company	
Insured Name, DOB, SS#	
Relationship to Patient	❑Self ❑Spouse ❑Mother ❑Father ❑ Other
Employer	

Medical Ins Company	
Insured Name, DOB, SS#	
Relationship to Patient	❑Self ❑Spouse ❑Mother ❑Father ❑Other
Employer	

Person financially responsible for the account (if different than patient)									
Address		**Apt#**		**City**		**State**		**Zip**	

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.
Please list below the individual's whom you allow us to give your clinical information to or answer questions from:

Name/Relationship:_____

Name/Relationship:_____

_____ _____
Patient Signature (or legal guardian if minor) Date

OUR OFFICE FINANCIAL POLICY

BASIC POLICY: **Payment is due at the time services are rendered**. The office will accept the following instruments for payment of services rendered: Visa, Mastercard, Discover, American Express and Cash.

- To assist our patients, we offer financial arrangements thru a third party vendor. Please ask our office staff for additional information and/or an application to apply.

If payment has not been made to an account 90 days after service is rendered, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities.

FOR PATIENTS WITH INSURANCE: **As a service and courtesy to our patients, we will file your primary insurance. This courtesy does not relieve the patient of financial responsibility nor suspend payments until the insurance has paid.** Every effort will be made to estimate your co-payments and deductibles with assistance from your insurance provider. The insurance provider does not guarantee payment during the verification process. The charges for services rendered by this office are the responsibility of the patient or patient guarantor. Co-payment and deductible fees are due at the time of service. Please understand that the insurance provider is a contract between you and your insurance company. **If an insurance carrier has not paid within 90 days of billing, any unpaid professional fees are due and payable in full from you.** Please be advised to follow up with your insurance company to be sure that they are processing your claim.

- This office will file on primary insurance only. It is the patient's responsibility to file with their secondary insurance. Our office will file dental extractions to medical insurance only if required by the dental insurance carrier.
- For patients with no insurance, fees will be due and payable at the time of service.

Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Be aware that some of our services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

NON-COVERED SERVICES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. Guarantor/Patient's Signature_____Date_____

PERSONAL INJURY CASES: This office does not accept liens or bill for auto-accident or other liability or lawsuit-related cases. It is the patient's **responsibility** and **obligation** to pay at the time of service.

FOLLOW-UP VISITS/AFTER HOURS: Periodic postoperative office visits may not be covered under your insurance plan; however, these may be required by the attending doctor to monitor your health. A $25.00 fee will be charged to the patient for after hour calls made to the physicians for non-surgical patients.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at a low cost to our patients, and in fairness to other patients and the doctor, we require **48 hours** notice when canceling an appointment. There is a **$75.00 fee for office visits** not canceled within 48 hrs prior to the appointment. **Scheduled surgery** appointments require **48 hours** notification to reschedule or cancel, or if you do not show up for the surgery, a **$150.00 fee will be charged** and payable from you. The practice reserves the right to dismiss patients with excessive canceled appointments. A separate policy exists for peak surgery scheduling time during the year (i.e. spring break, summer breaks, and fall/winter breaks).

DELINQUENT ACCOUNTS: Should your account become delinquent for nonpayment, you will be reported to the collection service.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage, please read and sign below:
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plans to Metroplex Surgical Arts, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid was the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor / Patient's Signature X_____ Date _____

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I am ultimately responsible for all fees for services provided to me.

Guarantor / Patient's Signature X_____ Date _____

Witness Signature _____ Date _____

Howard F. Cooke, D.M.D., M.S.
Diplomate, Oral and Maxillofacial Surgeon

CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name _____Date of Birth _____

SSN _____

My personal health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his/her staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that my doctor or his/her staff can give me called the "Revocation of Consent for Use and Disclosure of Health Information"; or

2) Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice," If I ask, the doctor and his/her staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

_____ _____
Patient (or legally authorized individual) signature Date

_____
Relationship to patient (parent, legal guardian, etc.)

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial, including any medical information contained therein, to _____ (Dr. or practice name), it's business associates, employees, licensees, and successors. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations and the HITECH Act.

Purpose: The photographic/video images, and/or testimonial will be used for Social Media and/or Advertising

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions: I understand that my practitioner cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

☐ "Yes, I would like a copy of this form." (initialed by team member, copy provided by _____)

Dr. or Practice Name: _____

Patient Name: _____
Date: _____
Signature: _____

If Personal Representative:
Name: _____
Date: _____
Signature: _____
Relationship to Patient: _____

If Patient is a Minor:
Parent / Legal Guardian: _____
Date: _____
Signature: _____

Covered Entity (Practice) Name: _____

Address: _____
_____