

**Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Drivers License Number \_\_\_\_\_ State \_\_\_\_\_  
Marital Status:  single  married  divorced  child  other  
Whom may we thank for referring you to our office \_\_\_\_\_

**Responsible Party**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

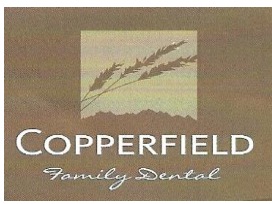
**Insurance Information**

Primary Insurance _____	Secondary Insurance _____
Name of Insured _____	Name of Insured _____
Address of Ins Co. _____	Address of Ins Co. _____
Contract ID# _____	Contract ID # _____
Group # _____ Phone _____	Group # _____ Phone _____
Insured DOB _____	Insured DOB _____
Employer _____	Employer _____

**Emergency Contact Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation to Patient \_\_\_\_\_

I hereby certify that the answers to the above questions are accurate to the best of my knowledge.



As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable in full at the time of service. There will be a fee, of \$50 per hour missed, assessed for missed appointments or appointments canceled with less than 24 business hours notice.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is responsible for payments of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collection received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. The patient also understands that they are responsible for any services not paid for by their insurance company.

A service charge of 1/5% per month (annual percentage rate 18%) on the unpaid balance will be assessed on all accounts exceeding thirty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services, or within thirty days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of further term or condition, and I further agree to pay all costs and reasonable attorneys fees if suit be instituted hereunder to collect monies owed by me, including interest charges, processing fess or commission (up to an additional 50% collection fee) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home, cellular phone or workplace to discuss matters relating to this form. I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Copperfield Family Dental.

I certify that I have answered all questions on the forms accurately and I hereby agree to abide by the conditions outlined therein.

\_\_\_\_\_  
Signature of patient, parents, guardian or representative      Date      Relationship to patient

**Acknowledgement of Receipt of Notice of Privacy of Practices**

I, \_\_\_\_\_, have received a copy of this offices' Notice of Privacy and Practices  
Print Name

\_\_\_\_\_  
Signature of patient, parent, guardian or representative      Date      Relationship to Patient

**Patients Dental Health**

How long since your last dental Check Up? _____	
Are you nervous about seeing a dentist? [ ] yes [ ] no	
How often do you brush?	Do you floss? [ ] yes [ ] no
Y N I clench or grind my teeth during the day or while sleeping	Y N I have had orthodontics
Y N My gums bleed while brushing or flossing	Y N I have had a facial or jaw injury
Y N I like my smile	Y N I want my teeth whiter
Y N I avoid brushing part of my mouth due to pain	Y N Tell me about cosmetic dentistry
	Y N Tell me about dental implants

**Patients Medical History**

I consider my health to be: [ ] Excellent [ ] Good [ ] Fair [ ] Poor	
<b>Do you or have you had any of the following?</b>	
Y N Heart Disease Y N Heart Murmur/Mitral Valve Prolapse Y N Stoke Y N Congenital heart Lesions Y N Rheumatic Fever Y N Abnormal Blood Pressure Y N Anemia Y N Prolonged Bleeding Disorder Y N Tuberculosis or Lung Disease Y N Asthma Y N Hay Fever Y N Sinus Trouble Y N Epilepsy/seizures Y N Ulcers Y N Implants/Artificial Joints [ ] Hip [ ] Knee [ ] Other When? _____ Y N I smoke or use tobacco. Y N I usually take an antibiotic prior to dental treatment	Y N Have you ever taken Fen-Phen or Redux Y N Liver Disease Y N Jaundice Y N Hepatitis. Type _____ Y N Diabetes Y N Herpes Y N Arthritis Y N Sexually Transmitted/Venereal Disease Y N Kidney Disease Y N Tumor or Malignancy Y N Cancer/Chemotherapy Y N Radiation Treatment Y N History of drug Addiction Y N AIDS Y N Immune Suppressed Disorder Y N Glaucoma Y N Fainting
Y N I have had major surgery: Year _____ Operation _____	
<b>WOMEN</b>	
Y N Are you taking birth control medication?	
Y N Are you or could you be pregnant or nursing?	

**Are you allergic to any of the following?**

Y N Aspirin	Y N Codeine
Y N Ibuprofen	Y N Latex
Y N Sulfa Drugs	Y N Local Anesthetics
Y N Penicillin	Y N Other _____

Consent to Proceed

I authorize Dr. Jonathan R. Elmer and/ or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician and/or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____	_____
Patient name	Signature of Patient, Parents or Guardian
_____	_____
Date	Signature of Dentist or Staff

**Review of Medical History**

I have reviewed the foregoing Medical History (other side) and find it to be unchanged and accurate except as noted:

_____	_____	_____
Signature of Patient, Parents or Guardian	Date	Updated Information
		_____
		Signature of Dentist or Staff