PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First (Preferred)

Sex (please circle): Male Female Family Status (please circle): Married Single Child Other

Social Security #: _____ Date of Birth: _____

Phone (home): _____ (Cell): _____

(work): _____ (Other): _____

Address: _____
Street Apartment/Suite/Unit #

_____
City State Zip Code

Email: _____
Please PRINT legibly. We use emails to confirm appointments and other office-patient correspondence.

HEALTH HISTORY

Do you currently or have you ever had any of the following? Please check all that apply:

- Acid Reflux
- AIDS/HIV
- Allergies:
  _____
  _____
- Anemia
- Artificial Joint
- Arthritis
- Asthma
- Blood Disease
- Cancer:
  _____
- Coumadin
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Frequent Headaches
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Attack
- Heart Murmur
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Hypothyroidism
- Jaundice
- Kidney Disease
- Liver Disease
- Multiple Sclerosis
- MVP
- Mental Disorders:
  _____
- Nervous Disorders
- Pacemaker
- Pregnancy
  Due date: _____
- Radiation Treatment
- Respiratory Treatment
- Rheumatism
- Sinus Problems
- Sleep Apnea
- Smoker/Tobacco User
- STD/STI
- Stomach Problems
- Stroke
- Thyroid Disease
- Venereal Disease

PRE-MEDICATION REQUIRED:
_____

PLEASE CHECK IF NONE OF THE PRECEDING HEALTH CONDITIONS APPLY – Initial here: _____

Please list any medications taken on a regular basis:

_____

Do you have any health problems that need further clarification?

_____

Are you currently under the care of a physician? If yes, please explain:

_____

Name of Physician: _____ Phone: _____

City, State: _____

To the best of my knowledge, all of the preceding information provided is true and correct. If I experience any changes in my health, I promise to inform Dr. Cooper and his staff at my next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

INSURANCE INFORMATION

The following information is requested of the PRIMARY insurance holder:

Name of Primary Insured: _____
Last First (Preferred)

Sex (please circle): Male Female Relationship to Patient (please circle): Self Spouse Child Other

Social Security #: _____ Date of Birth: _____

Insurance Carrier: _____ Employer: _____

PLEASE PROVIDE US WITH YOUR INSURANCE CARD

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

☐ Friend	☐ School	☐ Newspaper
☐ Relative	☐ Work	☐ Yellow Pages
☐ Another Dental Office	☐ Magazine	☐ Online

Name: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, payment is expected when services are rendered. Financial responsibility on the part of each patient will be determined prior to receiving treatment or other services; however, your financial responsibility may change in the event of a dental emergency or in the event that Dr. Cooper deems necessary changes to treatment during your appointment (i.e. additional surfaces, necessary changes in procedures, etc.).

All emergency dental services, or any dental services performed without previous financial arrangements, as stated above, must be paid IN FULL at the time services are rendered. **Personal checks WILL NOT be accepted as a form of payment for emergency services.**

Patients who carry dental insurance understand that **all dental services rendered are charged directly to the patient, or responsible party, and that he or she is personally responsible for all charges incurred.** Our office will prepare your insurance claims and apply insurance payments directly to your account. In the event that any claim is denied, **for any reason**, our office will *assist* you in making collections from your insurance carrier; however, our office cannot render services on the assumption that your charges will be paid by your insurance carrier.

An interest rate of 18% will be charged to your account monthly on any unpaid balance(s) exceeding more than thirty (30) days, unless previously written financial arrangements are satisfied. An account that goes unpaid for more than sixty (60) days will be regarded as a matter for collections. If your account advances to collections, you are financially responsible for all costs that may incur in collecting on said account (i.e. attorney fees, filing fees, court costs, etc.).

I understand that the treatment fee estimate for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

At the time services are rendered to me, I agree to pay the fee(s) of all said services to Grayhawk Dental Associates (Dr. Mitchell Cooper). I further agree that the fee(s) of said services shall be billed unless objected to, by me in writing, within the time for payment thereof.

By signing this form, I hereby consent Grayhawk Dental Associates (Dr. Mitchell Cooper) to provide dental services to me, or the patient whom I am responsible for, listed on the first page of this form. I grant my permission to Grayhawk Dental Associates' staff to telephone or email me at any of the telephone numbers and/or email addresses provided to discuss matters related to this form.

_____ _____
Signatures of patient, parent or guardian Date

FINANCIAL & CANCELLELATION AGREEMENT

IF YOU HAVE DENTAL INSURANCE:

Your insurance is a benefit to you. As a courtesy, our staff will coordinate your dental benefits and send claim forms along with any required correspondence to your insurance carrier. The information our staff receives from your insurance carrier regarding your dental benefits is an *estimate* and is not guaranteed until it has been reviewed and authorized by a professional representative from your insurance carrier. Services not covered by your insurance carrier due to waiting periods, or any other reason(s) specified by your insurance carrier, are **YOUR RESPONSIBILITY** and are to be paid **IN FULL** at the time services are rendered, or upon rejection of your claim.

WE DO NOT ACCEPT SECONDARY INSURANCE due to numerous limitations placed by insurance carriers regarding coordination of benefits and several policies. **Your portion is due regardless of the secondary coverage.** You are responsible for submitting any claims and necessary correspondence to your secondary insurance carrier for reimbursement.

IF YOU DO *NOT* HAVE DENTAL INSURANCE:

OUR OFFICE DOES NOT EXTEND PAYMENT PLANS. Payment is due in full at the time services are rendered. Our office accepts Visa, MasterCard, Discover, American Express, Care Credit, debit cards and cash. NO PERSONAL CHECKS, PLEASE.

COLLECTION PROCEDURES:

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. In the event that there is an unpaid balance on your account for more that thirty (30) days, we reserve the right to begin charging interest on your account. Our office will charge your account 18% of your outstanding balance per month. Any account balance that goes unpaid for sixty (60) days or more will be regarded as a matter for collections. If your account advances to collections, YOU ARE RESPONSIBLE for all costs that may incur in colleting said account (i.e. attorney fees, filing fees, court costs, etc.).

CANCELLING & RESCHEDULING APPOINTMENTS

Broken appointments (less than 48 hours given notice) are a significant contributor to rising healthcare costs, and we make every attempt to remind you of your upcoming appointments either by telephone, postcard and/or email. Please notify our office in advance (at least 48 hours prior to your scheduled appointment) if you need to cancel or reschedule your appointment(s). If you completely fail to notify our office, our staff will flag your chart with a "failed appointment," and a $56.00 failed appointment fee will be charged to your account. A failed appointment that is scheduled for longer than one (1) hour will result in a failed appointment fee of $100.00.

** IT IS OUR OFFICE POLICY THAT THE FOLLOWING SECTION MUST BE ** COMPLETED IN ITS ENTIRETY TO RECEIVE TREATMENT IN OUR OFFICE.

I have read and fully understand this Financial & Cancellation Agreement, and I agree to the terms listed above. I understand that I am financially responsible for all the charges incurred, also in the event in which my insurance carrier denies payment after a claim has been submitted by Grayhawk Dental Associates (Dr. Mitchell Cooper).

_____ Date: _____

Please PRINT patient or responsible party's name

_____

Patient or responsible party signature

HIPAA FORM
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations and of the uses and disclosures we may make of your protected health information.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain those changes. These changes may apply to any of your protected health information that we maintain. Revised copies of our Privacy Practices are issued to the patient or responsible party upon request.

Right to Revoke: You have the right to revoke this consent at any time by giving us WRITTEN NOTICE of your revocation. This written notice must be submitted in its original form, in person or by mail. *Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you, or continue treating you, if you revoke this consent.*

ACKNOWLEDGEMENT

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ Date: _____
Signature of patient, parent or guardian

*** If this consent is being signed by a personal representative on behalf of the patient, please complete the following (does NOT include parents of minors):**

Personal Representative's Name (please print): _____

Relationship to Patient: _____

REVOCATION OF CONSENT

Please only sign here if you wish to revoke your consent, otherwise leave blank

I hereby revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat, or continue to treat me, after I have revoked my consent.

_____ Date: _____
Signature of patient, parent or guardian

****SIGNATURE IS REQUIRED ON THE BACK OF THIS FORM****

IT IS OUR OFFICE POLICY THAT THIS FORM BE READ, ACKNOWLEDGED AND SIGNED *PRIOR* TO YOU BEING SEEN BY ANY HEALTHCARE PROFESSIONAL IN OUR OFFICE.

This form outlines and explains in-depth all information pertaining to the treatment you will be receiving in our office including general dental cleanings, oral exams and x-rays. Dr. Cooper will individually go over patient-specific treatment during your initial visit.

YOUR TREATMENT PLAN

Once Dr. Cooper has performed a recent dental examination and advised you of the present condition of your teeth and gums, you will be presented with a customized treatment plan which has the goal of improving the function and/or appearance of your teeth and gums. Your treatment plan should involve one, or a combination of, the following (perhaps along with other recommended dental procedures): veneers, crowns, bonding, inlays, onlays, whitening, root canal therapy, gum contouring or tooth contouring. Below are summary descriptions of these procedures. You will also be shown photographs and/or x-rays of Dr. Cooper's recommended procedures for you as illustrations of the primary procedures of your proposed treatment plan.

DESCRIPTIONS OF CERTAIN DENTAL PROCEDURES

Porcelain Veneers are shells of porcelain that are bonded to the teeth. This procedure requires some roughening or reduction of the outer tooth structure. Dr. Cooper will endeavor to minimize the tooth reduction necessary, under the circumstances, to achieve the desired aesthetic and functional results. At a later visit, the veneers are bonded onto the prepared teeth. The veneers may be designed and fabricated in a variety of shapes and sizes to modify the appearance and function of the teeth, including a V-shape that covers the front and backside of the teeth.

Crowns are life-like looking tooth restorations made out of porcelain, or porcelain plus other materials. A crown covers the entire tooth structure. Typically more tooth structure is removed to prepare for a crown placement than a veneer. Crowns may be recommended for teeth requiring additional support due to loss of healthy tooth structure.

Bonding is a term that is commonly used to refer to the placement of composite resins on teeth. Bonding can be used to make a tooth colored filling for small cavities and to also repair broken or chipped tooth surfaces. It can also be used to close spaces between teeth.

Inlays or Onlays may be the recommended treatment when individual back teeth are broken down but retain enough healthy tooth structure to allow for restoration of certain voids in the tooth structure. The tooth is prepared much like a normal filling or a short crown. The restoration material is custom fabricated out of composite resins, porcelain or porcelain and gold bonded into the void.

A ***Bridge*** is a replacement made for missing teeth. It is composed primarily out of porcelain and zirconia, which is bonded to adjacent teeth. These abutment teeth may require some reduction or crowning in order to support the teeth being replaced.

Whitening is performed by applying peroxide to the teeth. This can be done in our office or by a take-home system. The peroxide reacts with the tooth structure to safely whiten the teeth. Porcelain or composite restorations will NOT whiten.

Root Canal Therapy consists of the removal of infected or irritated nerve tissue that lies within the root of a tooth. This is a possible risk when tooth structure is removed from a tooth, decay is present and removed, the tooth receives trauma or your natural tooth structure fractures under an existing restoration. If the remaining natural tooth is insufficient in size to retain a restoration, an endodontist, or Dr. Cooper, will perform a post-and-core to rebuild the missing tooth structure and an additional procedure, probably a crown, will be needed. An additional fee will be applied to this service. This procedure can also occur if a veneer de-laminates and requires a crown to be fabricated.

Tooth Contouring is the reshaping of existing tooth structure by removing small amounts of the tooth structure itself. We give particular attention to the edges of the upper and lower front six (6) teeth, which may be reshaped to create a more aesthetic result.

Gum Contouring is the reshaping of the gum tissue, which is many times done to give a more symmetrical appearance. Depending on the location of the bone, you may be referred to a periodontist to have this procedure accomplished.

CUSTOM PREPARATION

Each person is unique and presents a different set of circumstances. Some of these circumstances are not revealed until during the procedure itself (for example, decay hidden under old crowns) or after. Therefore, the exact nature of the tooth and gum preparation for your treatment plan may vary somewhat from tooth-to-tooth, and may vary from the general descriptions of what you have read above or seen elsewhere depending on the amount of decay (if any) present, the shape and position of the teeth, and the desired look and function of the final restorations. As a result of these and other reasons, the exact nature and contours of the preparation of your teeth, and the resulting restorations, cannot be known until they are performed. During the course of treatment, unknown or unforeseen conditions may be revealed that necessitate a modification of the proposed treatment plan. Dr. Cooper will exercise his professional judgment to perform a conservative preparation of your teeth and to make other necessary decisions regarding the means, manner and method of any procedures, as they deem appropriate to achieve the desired results of the treatment plan or as they otherwise deem advisable under the circumstances.

SPECIFIC RESULTS NOT GUARANTEED

Dental procedures have an extremely high degree of success in our practice. Human tissues, however, react differently to dental treatment depending on a variety of factors. Each individual case is different, if not impossible, to guarantee. Thus, as with any branch of medicine or dentistry, the proposed treatment plan contains no guarantee of specific results. There are many variables that affect how long restorations or whitening can be expected to last including general health, maintenance of good oral hygiene, regular dental check-ups, etc. Natural teeth themselves are not "perfect" and contain certain embrasures, striations and color variations. Dr. Cooper will use his artistic skills to specify the shades, coloring, shape and sculpting of the restorations to make what are, in his experience, very realistic replicas of teeth. As with any type of artistic endeavor, however, aesthetics is a highly subjective perception. Once your approval is given, the restorations are placed. Any re-dos based on the shade, coloring, shape, sculpting and/or other aesthetic issues will be at Dr. Cooper's direction and at its then current rates. Therefore, you may want to bring a friend or loved one to attend the cementation appointment to assist in your approval of the restoration(s). If a veneer de-laminates repeatedly or fractures, a new procedure of a crown may be necessary at the current fee schedule.

ALTERNATIVE TREATMENTS

There are alternative treatments to Dr. Cooper's recommended treatment plan which may include, but are not necessarily limited to, one or more various combinations of veneers, crowns, bonding, inlays, onlays, whitening, contouring of teeth and/or gums, bridges, root canal therapy, fillings, orthodontics, non-surgical therapy, surgical curettage or cleaning, tooth extractions and implant treatments, as well as other unspecified dental treatments. Please make sure you have had plenty opportunity to ask about these alternative treatments and have had them explained to your satisfaction.

NON-TREATMENT OPTION

You do have the option to refuse Dr. Cooper's suggested treatment plan, and have no dental treatment(s) performed. This decision may entail a number of actual and/or potential risks, which are difficult or impossible to quantify or predict for specific cases. Some of the risks of non-treatment may include, but are absolutely not limited to, exacerbation of any existing symptoms, deterioration of the aesthetics and/or function of your teeth, improper biting, tooth, head and/or neck pain, fracturing of your teeth, discoloration and/or staining of your teeth, rotation and/or movement of you teeth, TMJ complications, additional wear to your teeth to the point they become candidates for reconstruction, loss of your teeth, bite problems, poor chewing, loosening of your teeth, need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, abscesses and/or infection(s), pain, tooth sensitivity, tooth movement, worsening periodontal condition, deeper pockets and other oral health problems.

RISKS AND INCONVENIENCES

Inherent in your proposed treatment plan (as well as with many similar or other dental procedures) are certain actual potential risks and inconveniences, which vary based on individual circumstances and variations in teeth and gums. These risks and inconveniences may last for a short or an indefinite length of time. They include, but are not necessarily limited to, swelling, pain, tooth sensitivity, bleeding, bruising discoloration, gum recession, abscesses, the need to repeat all or part of the procedure for known or unknown reasons, gagging, exposure of crown margins or edges, numbness; gum, bone or teeth inflammation, lisping, speech impediments or speaking difficulties, infection(s), virus, changes in facial appearance, stretching of the mouth resulting in cracked corners, stiffness of facial muscles, changes in occlusion, tooth mobility, loss of teeth, oral surgery, food impaction, root staining, oral opening restriction, tissue sloughing, continued periodontal disease, implant rejections, root canal therapy; numbness of the lips, chin and gums, dental neuropathy; temporary or permanent numbness or tingling in the lip, tongue, teeth, gums, chin, cheek or jaw area, nerve problems, parasthesia, joint pain/disorder, need for a night guard, accidental nicks or cuts from dental instruments or broken needle sticks to the body; injuries to the adjacent facial area, other tissues and teeth, fillings in other teeth, sutures; chipping, breaking or loosening of temporary or final restorations, de-laminations of veneers, accidental swallowing or aspirating of restorations, materials or dental tools; referred pain to the ear, neck jaw or head, temporalmandibular joint (jaw joint) problems, nausea, allergic reaction(s), bone fracture, delayed healing, sinus complications; adverse reaction to drugs, medications and/or anesthetic (including nitrous oxide), respiratory distress, heart failure or death. You understand that your condition may be the same, better or worse after treatment. If previously placed dental restorations are in place on your teeth, the treatment plan may entail additional alteration of tooth structure to properly prepare these teeth for new restoration and/or other unknown or unspecified problems or risks, which Dr. Cooper may or may not have encountered, and which are difficult or impossible to predict quantity.

MAINTENANCE OBLIGATIONS

For successful treatment results to lessen the dangers of complication, you agree to comply with your individualized maintenance program and keep excellent oral hygiene. It is typical to need follow-up visits for occlusal or other adjustments. You agree to notify Dr. Cooper at the soonest possible moment in the event that you experience pain or discomfort that you believe may be related to Dr. Cooper's treatment. You agree to keep your follow-up appointments and to follow recommended treatment on your treatment plan, as well as follow other precautions and recommendations that may be provided as part of your pre-operative or post-operative instructions. Veneers can break, chip or de-laminate. If this occurs, a re-cementation or re-fabrication fee along with additional emergency fees may apply.

NIGHT GUARD

Patients who exhibit signs of bruxism, grinding, clenching, occlusal wear or bite issues may fracture or de-laminate veneers and crowns. An occlusal guard (night guard) will be prescribed to protect the porcelain. One that is worn consistently every night does not guarantee perfect retention, but decreases the risk of de-lamination and fractures.

CONSENT

By signing below, I acknowledge that I have been given the time to read, and have read, the preceding information on all pages of this document. I agree to assume the risks and inconveniences of my treatment. I understand that Dr. Cooper will explain to me, in general terms, the diagnosis of my condition, the basis for his treatment plan recommendations, general descriptions of the proposed treatment plan, the alternatives (including non-treatment) and the risks and inconveniences. I assume the opportunity to ask any questions and any such questions will be answered or explained to my satisfaction.

I consent to the making of records (x-rays, photographs, prescriptions, treatment, healthcare operations, payment and the disclosure of my personal information) before, during and after treatment. Dr. Cooper's office may disclose my records to dental laboratories, lectures, other dental doctor's offices or professionals and to my insurance provider(s), which pertain to my dental treatment.

I, _____, understand this form and consent to agree with the terms of the treatment as described herein:
PRINT PATIENT NAME

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE