New Patient Information

Please bring your completed information to your first visit. If you are unable to complete the form prior to your visit you may arrive early to do so in our office.

Cook Periodontics & Dental Implants
Great Smile

Name: _____
(Last) (First) (Middle) (Preferred Name)
Home Address:
_____
(Street)
_____
(City) (State) (Zip)
Billing Address (If Different from Above):
_____
(Street)
_____
(City) (State) (Zip)
Social Security Number: _____ Marital Status: M S Other
Date of Birth: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ Ok to Receive Text Messages? Yes No
Email Address: _____
Appointment Confirmation Preference: _____
Preferred Pharmacy and Location: _____

Emergency Contact
Emergency Contact: _____ Relationship: _____
Address: _____
(Street)
_____
(City) (State) (Zip)
Phone Number: _____

Employment Information
Employer Name: _____ Occupation: _____
Address: _____ Phone: _____
(Street) (City) (State/Zip)

Insurance Information
**If you have dental insurance, please complete the following with your primary insurance. We DO NOT file secondary insurance.

Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's Employer: _____ Birth Date: _____
Insurance Company: _____ Group #: _____
Ins Subscriber ID: _____ Phone: _____
Address: _____
(Street) (City) (State/Zip)

I understand that Dr. Deana C. Cook, Dr. Phyllis B. Cook and/or associates do not accept Medicare & will not file Medicare Claims.

_____
Signature of Patient/ or Responsible Party **Date**

I understand that I am responsible for any fees for professional services that are rendered. I certify that I have read and understand the above. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/ or Responsible Party **Date**

If you would like for us to assist you in processing your insurance forms, we need to have your signature on file. This gives us the authorization to release treatment information to your insurance carrier.

AUTHORIZATION TO RELEASE INFORMATION: By having your signature on file, we can use our own computer-generated forms, which may not be available for you to sign when your treatment is provided. I hereby authorize Dr. Deana C. Cook, DDS, MS and/or Dr. Phyllis B. Cook, DDS, MPH to release any information relating to my dental claims.

_____

(Signature) **(Date)**

By your signature, you also understand that this office does not participate with any medical or dental insurance company. We are happy to file your dental claims for you; however, any amount your insurance company and/or coinsurance considers over and above their usual allowance is your responsibility. We also will not submit claims to medical insurance companies for dental treatment.

_____

(Signature) **(Date)**

Your insurance company reserves the right to conduct reviews for possible errors in reimbursement and may request a refund for insurance payment issued in error.

I understand that in the event my **insurance** requests re-payment, that I am responsible for repayment to my insurance company.

_____

(Signature) **(Date)**

Patient Name: _____

Medical Alert: _____

Medical History

General Physician's Name and Location: _____

Have you taken any medication or drugs during the past two years? Yes No

Are you currently taking any medical drugs, or pills (including vitamins)? Yes No

If yes, please list name and dosage: _____

_____

_____

Have you ever taken prescription bisphosphonate medications (for osteoporosis)? Yes No

If yes, did you take the following: Fosamax Yes No Boniva Yes No

Actonel Yes No Reclast Yes No

Have you ever taken prescriptions for acid reflux (like Nexium, prilosec, etc.)? Yes No

If yes, for how long: _____

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No Why? _____

Have you been under the care of a medical doctor/specialist during the past two years? Yes No

If yes, for what? _____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	**Kidney Trouble**	Yes	No	**Daily Aspirin**	Yes	No
Chest Pain	Yes	No	**Diabetes**	Yes	No	**Venereal Disease**	Yes	No
Congenital Heart Disease	Yes	No	**Thyroid Problems**	Yes	No	**AIDS/HIV Positive**	Yes	No
Heart Murmur	Yes	No	**Glaucoma**	Yes	No	**Alzheimer's Disease**	Yes	No
High Blood Pressure	Yes	No	**Contact Lenses**	Yes	No	**Cold Sores/Fever Blisters**	Yes	No
Mitral Valve Prolapse	Yes	No	**Emphysema**	Yes	No	**Blood Transfusion**	Yes	No
Artificial Heart Valve	Yes	No	**Chronic Cough**	Yes	No	**Hemophilia/Bleeding Problems**	Yes	No
Heart Pacemaker	Yes	No	**Tuberculosis**	Yes	No	**Sickle Cell Disease**	Yes	No
Rheumatic Fever	Yes	No	**Asthma**	Yes	No	**Bruise Easily**	Yes	No
Arthritis/Rheumatism	Yes	No	**Hay Fever**	Yes	No	**Liver Disease**	Yes	No
Cortisone Medication	Yes	No	**Latex Sensitivity**	Yes	No	**Yellow Jaundice**	Yes	No
Swollen Ankles	Yes	No	**Allergies or Hives**	Yes	No	**Neurological**	Yes	No
Stroke	Yes	No	**Sinus Trouble**	Yes	No	**Epilepsy or Seizures**	Yes	No
Diet (Special/Restricted)	Yes	No	**Ulcers**	Yes	No	**Fainting or Dizzy Spells**	Yes	No
Tumors/Malignancy	Yes	No	**Nervous/Anxious**	Yes	No	**Artificial Joints (hip, knee, etc.)**	Yes	No
Radiation Therapy	Yes	No	**Psychiatric/Psychological Care**	Yes	No			
Chemotherapy	Yes	No	**Hepatitis A (Infectious) B (Serum)**	Yes	No			

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No

If yes, please list: _____

Women: Are you pregnant? Yes ___ Months No Nursing? Yes No Taking birth control pills? Yes No

Men: Are you taking erectile dysfunction medication? Yes No If yes, please list: _____

(Due to drug reactions with surgical procedures, this is a necessity for medical history purposes.)

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to be best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health or medication.

_____

(Patient/Guardian Signature) **(Date)**

Reviewed by: _____ Summary: ROS

(Doctor's Signature)

PSH

Patient Name:_____

Dental History

On a scale of 1-10, how important are your teeth to you? 1 2 3 4 5 6 7 8 9 10 (1 being the least, 10 being the most)

Do you have any dental problems now? Yes No

If yes, please describe: _____

Date of Last Dental Visit: _____ **Last Dental Cleaning:** _____ **Last Full Mouth X-rays**: _____

What was done at your last dental visit? _____

General Dentist Name: _____ Phone Number: _____

Address: _____ State: _____ Zip: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Electric toothbrush, proxabrush, toothpick, etc.) _____

What type or brand of toothpaste do you use? _____ Mouth Rinse: _____

Is there anything you would like to share with us that will make your visits more comfortable? _____

_____

Who can we thank for referring you to our office? _____

Please answer each question:

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth lose? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lip or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, keys, nails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke and-or Chew Tobacco? Yes No

If so, how much and how often? _____

Consume alcohol? Yes No

If so, how much and how often? _____

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to your mouth or head? Yes No

If so, please describe, including cause: _____

_____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

If yes, Where? _____

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

_____

Have you ever had a bad dental experience? Yes No

If so, please describe: _____

_____

Is there anything else regarding your dental treatment that you would like us to know? Yes No

If yes, please describe: _____

_____

(Patient/Guardian Signature) **(Date)**

Summary:

Reviewed By: _____

(Doctor's Signature)

Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

Cook Periodontics and Dental Implants are authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information	**Type of information to be released** Check each that can be given to the person/entity on the left in the same section
☐ **Voicemail**	☐ **Financial** ☐ **Medical/Treatment** ☐ **Appointment dates, times, and details**
☐ **Other person (provide name and phone number)** _____	☐ **Financial** ☐ **Medical/Treatment** ☐ **Appointment dates, times, and details**
☐ **Email Communication (provide email address*)** _____ *** For email communication to occur, please accept the disclosure below**	☐ **Financial** ☐ **Medical** ☐ **Appointment dates, times, and details**
☐ **Text Communication (provide number*)** _____ *** For text communication to occur, please accept the disclosure below**	☐ **Appointment dates, times, and details** ☐ **Other:**_____
☐ **General dentist/physician (provide name)** _____	☐ **Medical/Treatment** ☐ **Other:**_____

☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Rights:

- **I have the right to revoke this authorization at any time**
- **I may inspect or copy the protected heath information to be disclosed as described in this document**
- **Revocation is not effective in cases where the information has already been disclosed but will be effective going forward**
- **Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by feral or state law**
- **I have the right to refuse to sign this authorization and that my treatment will not be condition on signing.**

This authorization will remain in effect until revoked by the patient.

X_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Cook Periodontics & Dental Implants
Great Smile

Deana C. Cook, D.D.S., M.S.
Phyllis B. Cook, D.D.S., M.P.H.
Diplomates of the American Board of Periodontology
7028 Wrightsville Ave · Wilmington, NC 28403
(910) 256-8486 · Fax (910) 256-8449 · www.cook-perio.com

Financial, Insurance & Billing Information

Welcome to Cook Periodontics and Dental Implants! We are happy that you have chosen us for your periodontal needs. Once we have completed our comprehensive exam and have developed a treatment plan to meet your needs, we will discuss payment options.

1. Our practice is a fee for service dental practice. Payment is expected at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover and American Express. If necessary, we are able to provide low or no interest financing through our partnership with Care Credit. There will be a $25 return fee for returned checks.

2. We understand that you may have dental insurance. It is your responsibility to know your insurance plan. Our treatment planning is based on your needs as a patient and not according to your insurance coverage. We are happy to assist you in filing claims, but ultimately you are responsible for your treatment and the associated costs involved.

3. Every effort is made by our staff to give estimates for all treatment prior to the occurrence. We would like you to keep in mind that costs could change according to needed procedures that occur during performance of the treatment.

4. For all surgical procedures, 50% of the estimated fee is required at the time you schedule your appointment. The balance will be due the day of surgery. Any account not paid within 60 days will be sent to an outside collection agency.

5. Your time is important to us. We carefully schedule needed appointments in order to have an adequate amount of time for you. We require 2 business days (9:00am-5:00pm) notice to change any appointment. There is a $200 fee for surgery appointments that are cancelled or changed without 2 business days notice and a $25 fee for all other appointments. Cancellation or change appointment requests are not accepted via email, text or voicemail.

To acknowledge that you have read and understood our policy, please print and sign below.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Cook Periodontics and Dental Implants
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.
910-256-8486

Effective Date: April 14, 2003 **Revised: July 17, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **http://www.cook-perio.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative. Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment. **There is one exception**: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Dr. Deana Cook, DDS, MS
Address: 7028 Wrightsville Ave, Wilmington NC 28403
Telephone: 910.256.8486 Fax: 910.256.8449

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003 **or date practice adopted the Notice**

Cook Periodontics and Dental Implants

Deana C. Cook, DDS, MS and Phyllis B. Cook, DDS, MPH
7028 Wrightsville Ave. Wilmington, NC 28403
910.256.8486 Fax 910.256.8449

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name and Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

X_____ _____
SIGNATURE **DATE**

For Office Use Only

We were unable to obtain a written acknowledgement or receipt of the Notice of Privacy Practices because:

- o An emergency existed and a signature was not possible at the time
- o The individual refused to sign
- o A copy was mailed with a request for a signature by return mail
- o Unable to communicate with patient for the following reason:

_____

- o Other: _____
  _____

Prepared by: _____
Signature: _____
Date: _____