Cobalt Dental

Today's Date:

Patient's Name		Preferred Name	
Birth Date		Sex M F	
SS#		Single	Married Child
Home Address		E-Mail	
City	State	Zip	
Home #	Cell #	Work #	
Employer	Physician's Name_____	Phone Number_____	

How did you hear about Cobalt Dental?_____

Emergency Contact Information

Name	Family or Friend	Phone

Dental Insurance – Primary	**Dental Insurance – Secondary**
Policy Holder's Name	Policy Holder's Name
Policy Holder's DOB	Policy Holder's DOB
Group #	Group #
Ins. Co. Name	Ins. Co. Name
Ins. Co. Phone#	Ins. Co. Phone#
Subscriber ID #	Subscriber ID #

A copy of your HIPPA rights are available upon request.

Who would you like to be able to obtain your dental records and discuss your account?

Name:_____

Date:_____

FINANCIAL ACKNOWLEDGEMENT AND TREATMENT CONSENT

We provide services for our patients with the understanding that they **are responsible for all charges incurred for treatment.** As a courtesy, we will prepare claim forms to assist you in obtaining maximum benefits available. As a courtesy, Cobalt gives our patients ESTIMATES based on the information given to us by your insurance company. We treat every patient based on individual need, not what an insurance company deems necessary. Cobalt Dental has a relationship with YOU, our patient and not with your insurance company. Your benefits are an arrangement between your employer and insurance company. I release assignment of benefits to Cobalt Dental. **If your insurance ever downgrades your coverage for certain procedures or denies payment for your treatment, the balance is your responsibility. Cobalt Dental has no control over what your insurance pays us for your treatment. If there is a remaining balance after your insurance settles, the balance is YOUR responsibility. _____Initial**

I understand that if my account is not paid in full within 60 days of the statement received, I am liable for all costs of collection to include an attorney fee, court costs, reasonable interest, and reasonable collection agency fees.

I understand that if my account goes to collections that Cobalt Dental will not be able to see me as a patient due to a broken patient/doctor rapport. **I am also aware that if my account is placed with a collection agency that the agency will have knowledge of my dental treatment history.**

Cobalt Dental has my permission to share my dental treatment with other physicians/dentists to facilitate my treatment and overall health. I have provided correct medical information and do hereby give consent to necessary treatment, medication or anesthetics to be administered by the attending dentist and staff for diagnostic purposes and/or dental treatment. Furthermore, I will not hold the dentist or his staff responsible for any errors or omission that I have made in completing this form. I consent to electronic communication, as well as, phone calls to discuss treatment and billing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this HIPAA acknowledgement.

I have reviewed a copy of Cobalt Dental's notice of privacy practices. I understand my privacy is protected. I consent to allow Cobalt Dental to contact me by phone or email. **_____ Initial**

APPOINTMENT AGREEMENT FOR COBALT DENTAL

Because missed appointments increase the cost of healthcare for everyone, we appreciate your understanding in keeping scheduled appointments. If more than two appointments are missed, I understand that Cobalt Dental will not be able to see me as a patient due to a broken patient/doctor rapport.

Our providers reserve a specific amount of time for every patient. We never double book your appointment so that your appointment time is always honored by our staff. If you need to reschedule your dental appointment, we require a 24 hour courtesy notice so that we may provide the opportunity to a patient who is on our waiting list for an earlier appointment. **If 24 hours courtesy notice is not given, there is a $50 failed appointment fee that will be added to your account.** **_____Initial**

I understand and will honor Cobalt Dental's
financial agreement, **HIPAA acknowledgement**, and **appointment agreement:**

Patient or Guardian Signature _____ **Date**_____

NAME:_____

CHECK ALL THAT APPLY

- □ AIDS/HIV positive
- □ Artificial Joints
- □ Cancer
- □ Epilepsy
- □ Glaucoma
- □ Heart Murmur/Mitral Valve Prolapse
- □ Jaundice
- □ Mental Disorders
- □ Pregnant
- □ Rheumatic Fever
- □ Other _____
- □ CPAP

Medical History

- □ Anemia
- □ Asthma
- □ Diabetes
- □ Excessive Bleeding
- □ Head Injuries
- □ Hepatitis A B C
- □ Kidney Disease
- □ Nervousness/Depression
- □ Radiation Treatment
- □ Stroke
- □ Stomach Problems
- □ Sleep Apnea
- □ Arthritis
- □ Blood Disease
- □ Dizziness
- □ Fainting
- □ Heart Issues
- □ High Blood Pressure
- □ Liver Disease
- □ Pacemaker
- □ Respiratory Problems
- □ Osteoporosis
- □ Tobacco User (currently)

Allergies

- □ Aspirin
- □ Codeine
- □ Erythromycin
- □ Latex
- □ Nitrous Oxide
- □ Penicillin
- □ Percodan
- □ Seasonal
- □ Sulfa Drugs
- □ Valium
- □ Other_____

Current Medications:

_____

_____

Sleep Apnea

1) Do you often feel tired, fatigued, or sleepy during the daytime? Yes___ No___
2) Are you being treated for ADHD? Yes___ No___
3) Do you snore loudly (louder than talking)? Yes___ No___
4) Has anyone observed you stop breathing during your sleep? Yes___ No___

TMJ

1) Do you have frequent headaches? Yes___No___
2) Does your jaw “pop” or “click” when opening or closing your mouth? Yes___No___
3) Do you wake up with your jaw or face hurting? Yes___ No___
4) Does your jaw ever feel tight? Yes___ No___
5) Has anyone ever told you that you grind your teeth at night? Yes___No___
6) Do you clench during the day? Yes___No___

Implants

1) Do you have any digestive problems? Yes___ No___
2) Do you gag easily? Yes___ No___
3) Do you have difficulty with chewing? Yes___ No___
4) Is your diet limited to semisolid or soft foods? Yes___ No___

Signature:____ **Date:**__________________