Cope Dentistry, PA

Susan A. Cope D.D.S. John M. Cope D.D.S. Lindy A. Cope D.D.S.

PATIENT INFORMATION

Welcome to Cope Dentistry. To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name____ Preferred name ________________________Birth date_________________

If minor, parents names ___________________________________Cell phone ______________________Home phone______________________

Mailing Address ____City _________________________________State ___________ Zip ___________

Employer_______________________________________ Occupation__________________________ Work phone _________________________

E-Mail address ____Preferred method to be reached_____________________________________

Spouse's name __________________________________Spouse's employer____________________________________ ___Unmarried

BILLING.CREDIT AND INSURANCE INFORMATON: Covered by dental insurance: ___Yes ___No

Your Social Security number____________________

Your Dental Insurance Company _______________________Group number_______________ Member ID Number ___________________________

Covered by spouse's insurance? ___Yes ___No Spouse's dental insurance company _________________________Group number____________

Spouse Member ID Number ___________________Spouse's birthday_________________ Spouse Social Security number_______________________

Whom may we thank for referring you to our office? ____

MEDICAL HEALTH HISTORY

<u>Do you have or have you had any of the following?</u>
(Please check all that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Pacemaker
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Allergies or hives
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Neurologic condition
- ❑ Artificial joint or valve
- ❑ Epilepsy, seizures, or fainting spells
- ❑ High or low blood pressure
- ❑ Emotional disorder
- ❑ Arthritis
- ❑ Tuberculosis or other lung problems
- ❑ Herpes or cold sores
- ❑ Kidney disease
- ❑ AIDS or HIV positive
- ❑ Hepatitis or other liver disease
- ❑ Migraine headaches or frequent headaches
- ❑ Alcoholism
- ❑ Anemia or blood disorders
- ❑ Hay fever or sinus trouble
- ❑ Asthma
- ❑ Do you smoke or use chewing tobacco? ___Yes ___ No

<u>Are you allergic to, or have you reacted adversely to any of the following?</u>

- ❑ Penicillin or other antibiotics
- ❑ Latex materials
- ❑ Local Anesthetics (Novocain)
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin, Acetaminophen or Ibuprofen
- ❑ Other:________________________

<u>Are you taking any of the following?</u>

- ❑ Aspirin
- ❑ Blood thinners
- ❑ Non- prescription drugs/supplements
- ❑ Nitroglycerin or other drugs for heart trouble
- ❑ Cortisone or other steroids
- ❑ Antibiotics
- ❑ High blood pressure drugs
- ❑ Antidepressants
- ❑ Insulin or other diabetic drug
- ❑ Osteoporosis (bone density) drugs
- ❑ Other____________________________

<u>Women:</u>

- ❑ Are you pregnant?
- ❑ Taking hormones or contraceptives.

Name of your physician: ____

Have you been in the hospital in the last 2 years? If so, for what reason? ____

Do you have any disease, condition, or problem not listed above?____

How long has it been since you've seen a dentist?________________________ Reason for today's visit? ______________________________

Please add anything else you would like us to know about. ____

Signature of patient (or parent) ____Date______________________

COPE DENTISTRY, P.A.

Susan A. Cope, D.D.S. John M. Cope, D.D.S. Lindy A. Cope, D.D.S

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AS A PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our web sites and our privacy practices, our legal duties, and your rights concerning your health information. We are required to follow the privacy practices we describe in this notice while it is in effect. This notice takes effect 10/14/2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that any applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the content of our notice effective for all health information that we maintain, including health information we created or received prior to any changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to you upon request.

You may request a paper copy of this notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

OUR USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality

assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee

for providing your health information in that format. If you prefer, we may - but are not required to - prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before 01/01/2011). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing to our office. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, you may contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFO:

Cope Dentistry ATTN: Andrew M. Cope

9001 Roe Avenue Prairie Village, Kansas 66207

(913) 648-7700

andy@jocoland.com

COPE DENTISTRY, P.A.

Susan A. Cope, D.D.S.   John M. Cope, D.D.S.   Lindy A. Cope, D.D.S

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receipt of the Cope Dentistry, PA **"Notice of Privacy Practices"**.

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Signature

____

Print Name

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining the acknowledgement
Other (Please specify)

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08/2017