Thomas P. Cosgrove, DMD, PC

PATIENT INFORMATION

Name _____ Preferred Name_____
Last *First* *MI*

Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Minor

Birth Date: _____ Age: _____ Social Security # _____ DL# _____

Physical Address (No PO Box): _____

City _____ State _____ Zip _____

Billing Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation: _____

If Student, Name of School: _____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____

Sex: ☐ Male ☐ Female Birth Date: _____ Social Security # _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Employer _____ Occupation: _____

DENTAL INSURANCE COVERAGE

Insurance Company: _____ Policy # _____ Group # _____

*Provide an insurance card to the desk and answer the following questions.

PERSON PROVIDING INSURANCE (IF DIFFERENT THAN PATIENT)

Name _____

Birth Date _____ Social Security # _____ Employer: _____

Relationship to Patient: _____ Work Phone _____

REFERRED BY _____

IN CASE OF EMERGENCY NOTIFY _____ **PHONE** _____

CONSENT TO DENTAL TREATMENT: The undersigned consents to the dental procedures which may be performed during treatment at Thomas P. Cosgrove DMD, PC, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, oral surgical treatment or procedures, or local anesthesia rendered to the patient by the dentist.

RELEASE OF INFORMATION: I agree that to the extent necessary to determine liability for payment and to obtain reimbursement, the dentist may disclose portions of my dental records to any person or corporation which is or may be liable for all or any portions of the dentist's charges, including but not limited to insurance companies, dental or health care service plans, or workers' compensation carriers. I understand that dental information may also be released to review organizations and if necessary any agencies that may be involved in continuing patient care. I agree and acknowledge that this authorization and consent continue until such time as written notice revoking said consent from the patient or the patient's legal representative is received by the dentist. Such revocation as above stated will not apply retroactively to any previous disclosures made based on the original authorization.

Signature of Responsible Party _____ **Date** _____

3159 Green Valley Road, Birmingham, AL 35243
(205) 967-4080

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MEDICAL HISTORY

Physician Name: _____Date of last Physical: _____

Allergies: ☐**Penicillin** ☐ **Codeine** ☐**Latex** ☐**Sulfa Drugs** ☐**Other**_____

List all **Medications** including Prescriptions, Over the Counter, Herbs and Vitamins:

_____

_____

Are you under medical treatment now? If so, for what? _____

List of Hospitalizations in the last 5 years: _____

Check if you **Have Ever** experienced any of the following:

- ☐ Chest Pain (Angina)
- ☐ Easily Winded
- ☐ Bleeding Problems
- ☐ Bruise Easily
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Dry mouth

Check if you **Currently Have** or have **Ever Had** any of the following:

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Prosthetic Heart Valve
- ☐ Artificial Joints
- ☐ Pacemaker
- ☐ Blood Transfusion
- ☐ Tumors/Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatments
- ☐ Leukemia
- ☐ Epilepsy/Seizures
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Problems
- ☐ Aids
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Hay Fever/Allergies
- ☐ Other:_____
  _____
  _____

Do you use any of the following?

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational Drugs

Women Only: Are you Pregnant or Nursing? _____ Taking Birth Control Pills? _____

***** Some antibiotics alter the effectiveness of birth control pills

DENTAL HISTORY

Is there anything you would change about your smile? _____

Check if any of the following applies to you:

- ☐ Gums bleed during Brushing or Flossing
- ☐ Tooth Sensitivity to Hot, Cold or Sweets
- ☐ Lumps or Sores in you Mouth
- ☐ Jaw Pain, Popping, Clicking or Difficulty Chewing or Opening and/or Closing
- ☐ Clenching and/or Grinding
- ☐ Bite Cheeks or Lips frequently

Signature of Responsible Party _____ **Date** _____

I certify that the above information is complete and accurate and I will inform dentist of any change in health and/or medications.

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PATIENT CONTACT INFORMATION

Dr Cosgrove, staff, employee or representative of Dr Cosgrove has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Patient's Signature: _____ Date: _____

OR

I do not want anyone to have access to my protected health information unless I provide explicit authorization.

Patient's Signature: _____ Date: _____

***If any of this information changes, please let us know so we can update this form**

NON-COVERED SERVICES POLICY AND AGREEMENT

As your dentist I want to provide you with your choice of dental services. There may be some service available to you that are not covered by various dental insurance companies such as BCBSAL, Delta Dental and Cigna.

For any service listed as "non-covered" by your policy you will be expected to pay the difference between the alternative service fee provided by your insurance and this office's normal fee. For example, your contract may limit their coverage for a filling to a silver amalgam only, providing no benefits coverage whatsoever for a tooth colored composite filling. Also, many policies downgrade benefits for a porcelain crown to full metal crowns only. Any difference in fees in either example is the patient's responsibility. It is important to understand that any procedures considered cosmetic by your policy will NOT be covered by your contract and you will be responsible for payment in full for these services.

Please keep in mind that there are many different contracts available to you from the same insurance company and we can only estimate what they will pay.

Let us reassure you that only services necessary and appropriate for your care will be performed. As always we will be happy to help you with any questions you may have about your coverage's and choices. Thank you for your understanding and for choosing our office to help maintain your dental health.

Signature of Responsible Party _____ **Date** _____

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FINANCIAL AGREEMENT

***ASSIGNMENT OF INSURANCE BENEFITS*:** In the event the patient is entitled to dental care arising out of any insurance policy insuring patient of any party liable to the patient, said benefits are hereby assigned to Thomas P. Cosgrove DMD, PC for application on patient's bill, and it is agreed that this office may receipt for any such payment and such payment will discharge the said insurance company of any and all obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for charges not covered by this assignment.

***FINANCIAL AGREEMENT*:** The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account in accordance with regular fees and terms of this dental office. Furthermore, he will be obligated to make monthly payments if requested, and upon discharge, on the uninsured portion of the account. Should the account be referred to a collection agency or any attorney for collection, the undersigned will pay all reasonable attorneys' fees and collection expenses. Any accounts 90 days delinquent are subject to 18% annual interest charge on any un-paid balance. This office reserves the right to make appropriate entries on the undersigned's personal credit report in regards to any delinquency in their account with this office through Holloway Credit Solutions, LLC.

I, (we) hereby guarantee THOMAS P. COSGROVE DMD, PC, payment of all charges in accordance with its rules, regulations, and charges. Furthermore, I (we) hereby authorize and appoint the administrator of this office or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect any such claims or insurance proceeds by signing my name as attorney-in-fact to any such claims and/or forms.

THE UNDERSIGNED CERTIFIES that he has read the foregoing, and is the patient as patient's general agent to execute the above and accept its terms.
GUARANTEE OF PAYMENT, in consideration of dental services extended to this patient, I/we do hereby assume responsibility for the payment of all charges for such services in accordance with the financial agreement above.
BROKEN APPOINTMENTS: Canceled/Missed appointments without 24 hours notice are subject to a $25 fee.

***ALL DEDUCTIBLES AND CO-PAYS ARE DUE AT TIME SERVICES ARE RENDERD**

***IF YOUR CLAIM IS DENIED IN PART OR IN FULL THE PATIENT WILL BE FINANCIALY RESPONSIBLE**

Signature of Responsible Party _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Please Print Name) _____, have received a copy of this office's Notice of Privacy Practices.

Signature of Responsible Party _____ **Date** _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be attained because:
- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS DOCUMENT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US
AND IS OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices. This notice takes effect April 14, 2003.
We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Any changes will be made available to you.
You may request a copy of our privacy notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, email's, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

We support your right to the privacy of your health information. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may complain to us using the contact information listed at the end of this notice.

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