Thomas A. Copulos, D.D.S., P.A.
Practice Limited to Periodontics and Dental Implantology
1000 N.W. 9th Court, Suite 106 Boca Raton, FL 33486
561-338-7115

Welcome! Our goal is to make everyone's visit pleasant and educational. Please complete both sides of this form. This information is necessary to provide a treatment customized specifically for you.

Patient Information

Name_____ Today's Date_____
Birth date_____ Age_____ Sex_____ Soc Sec #_____
☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Address_____ Apt.# _____
City _____ State_____ Zip Code _____
Home # _____ Cell #_____ email_____
Occupation_____ How long employed?_____
Employer_____ Work # _____
Emergency Contact Name_____ Relationship_____ Phone #_____
Why are you seeking treatment? _____
Whom may we thank for referring you to this office? _____

Responsible Party

Responsible Party's Name_____
Soc. Sec. #_____ Birth date _____ Relationship _____
Employer_____ Work # _____

Primary Dental Insurance

Insurance Company Name_____ Phone #_____
Insurance Company Address_____
Plan _____ Group_____ Policy _____
Policy Owner's Name_____ Birth date _____
Policy Owner's Soc. Sec. #_____ Relationship to Patient_____
Policy Owner's Employer_____ Work # _____
Policy Owner's Employer Address_____
Do you have secondary dental insurance? ☐ Yes ☐ No Insurance Company Name _____
Plan _____ Group_____ Policy _____

Past Dental History

General Dentist_____ Phone #_____ How long?_____
Date of Last Cleaning_____ How often do you brush?_____ Brush Type_____
How often do you floss?_____ Other aids you use_____
Have you ever had? Orthodontics Extractions Deep Cleaning Periodontal Surgery Implants Crowns Bridges
Do you notice any of the following (**Circle all that apply**):

Gums Bleed on brushing /flossing	Hot or Cold Sensitivity	Bad Breath/Taste	Missing Teeth
Gaps between teeth	Food traps between teeth	Loose teeth	Teeth have shifted
Gums are Receding	Dry Mouth	Biting Sensitivity	Awake with headaches
Teeth Clenching/Grinding	Broken/chipped teeth	Jaws pop or click	Tired/sore jaw muscles

Are you happy with the appearance of your teeth? ☐ Yes ☐ No Specifically? ☐ Color ☐ Position ☐ Smile
Are you interested in replacing any missing teeth? ☐ Yes ☐ No Which method? ☐ Dentures ☐ Bridges ☐ Implants

I authorize Dr. Copulos to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the Dr. Copulos to use and employ such assistance as deemed to provide recommended treatment.

Signature of Patient(or Guardian)_____ Print Name _____

Dentist Signature_____ Date _____

Medical History

A thorough medical history is essential to investigate contributing causes and influences to your periodontal health. Please answer each question. Please inform us of any changes in your medical history in the future including any new medications or changes in your dosage. Your responses are only for our records and will be kept confidential.

Physician's name _____

Physician's Number_____

Physician's Address_____

Are you in good health now? ☐ Yes ☐ No

Were there changes in your general health this past year? ☐ Yes ☐ No
Explain _____
_____

Are you under the care of a Physician for a specific problem? ☐ Yes ☐ No
Explain _____
_____

List all medications and dosages you currently take: _____
_____
_____
_____

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No
Explain_____

Have you been treated with Bisphosphonates (Fosamax, Actonel, Boniva, Zometa) for osteoporosis or cancer? ☐ Yes ☐ No
Explain _____
_____

Are you pregnant or is it likely you are pregnant? ☐ Yes ☐ No

Do you require premedication before a dental procedure? ☐ Yes ☐ No

Do you?

☐ Smoke Packs per day?_____ How long? _____Years
☐ Chew Tobacco Times per week?_____ How long? _____Years
☐ Drink Times per week?_____ Per Month?_____
☐ Take Birth Control Pills _____
☐ Wear Glasses ☐ Wear Contact Lenses ☐ Have a Visual Change
☐ Take Herbal Supplements/Vitamins_____

Please mark an ALLERGIES/ADVERSE REACTIONS to the following:

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Barbiturates
☐ Yes ☐ No Codeine
☐ Yes ☐ No Latex
☐ Yes ☐ No Local Anesthetic
☐ Yes ☐ No Metal
☐ Yes ☐ No NSAID (Motrin)
☐ Yes ☐ No Penicillin/Sulfa
☐ Yes ☐ No Tetracycline
Other_____

Mark if you have or have ever had (check Yes or No):

Y	N		Y	N	
☐	☐	Acid Reflux	☐	☐	Heart Murmur
☐	☐	Addiction	☐	☐	Heart Surgery
☐	☐	AIDS/ARC/HIV	☐	☐	Hepatitis A or B or C
☐	☐	Anemia	☐	☐	High Blood Pressure
☐	☐	Angina/Chest Pain	☐	☐	High Cholesterol
☐	☐	Appetite Change	☐	☐	Hives/Rash
☐	☐	Artificial Joint	☐	☐	Jaundice
☐	☐	Artificial Valve	☐	☐	Joint Surgery
☐	☐	Arthritis	☐	☐	Kidney Problems
☐	☐	Asthma	☐	☐	Liver Problems
☐	☐	Aspirin Daily	☐	☐	Migraines
☐	☐	Atrial Fibrillation	☐	☐	Mitral Valve Prolapse
☐	☐	Bell's Palsy	☐	☐	Mouth Ulcers
☐	☐	Blood Disorder	☐	☐	Night Sweats
☐	☐	Blood Thinner	☐	☐	Numbness/Tingling
☐	☐	Blood Transfusion	☐	☐	Organ Transplant
☐	☐	Breathing Problem	☐	☐	Pacemaker
☐	☐	Bronchitis	☐	☐	Phen-Phen Use
☐	☐	Bruise Easily	☐	☐	Prolonged Bleeding
☐	☐	Cancer/Chemotherapy	☐	☐	Psychiatric Therapy
☐	☐	Chest Pain	☐	☐	Radiation Therapy
☐	☐	Chronic Cough	☐	☐	Recurrent Infection
☐	☐	Chronic Diarrhea	☐	☐	Rheumatic Fever
☐	☐	Claustrophobia	☐	☐	Short of Breath
☐	☐	Diabetes	☐	☐	Sinus Problems
☐	☐	Dizziness/Fainting	☐	☐	STD
☐	☐	Emphysema	☐	☐	Stomach Problems
☐	☐	Epilepsy	☐	☐	Stroke/TIA
☐	☐	Fever-Persistent	☐	☐	Thirsty Frequently
☐	☐	Frequent Nose Bleeds	☐	☐	Thyroid Problems
☐	☐	Glaucoma	☐	☐	TMJ
☐	☐	Hay Fever	☐	☐	Tuberculosis
☐	☐	Headaches	☐	☐	Ulcers/Colitis
☐	☐	Head Injury	☐	☐	Urinate Frequently
☐	☐	Hearing Loss	☐	☐	Weight Change
☐	☐	Heart Attack/Surgery	☐	☐	Venereal Disease

Disease or Condition you feel is important that we know: _____
_____
_____

Doctor's Notes

_____
_____

Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collection will be charge the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask relevant dental and medical questions and thus fully understand the cost, time, limitations and potential complications of any dental they agree to receive. The dental profession cannot be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of this dental staff responsible from any errors or omissions that I have made in the completion of this form. I will not hold Dr. Copulos or his staff responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form.

Accept Assignment: My signature authorizes the release of necessary information needed to process my claim and to pay benefits to the provider of service.

_____ _____ _____

SIGNATURE OF PATIENT OR GUARDIAN (if minor) Print Name DOCTOR'S SIGNATURE DATE

Update_____Comment_____ Initials_____
Update_____Comment_____ Initials_____
Update_____Comment_____ Initials_____

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PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME_____ Date of Birth_____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Please check below the persons and/or facilities authorized to receive and/or discuss your dental information.

Check each person/entity that you approve to receive information.	Check each that can be given to person/entity o the left in the same section
❑ Voice Mail ❑ Text Message ❑ Email address_____	❑ Results of lab tests, X-rays, Appointment reminders, etc ❑ Other_____
❑ Spouse (provide Name and Phone number) _____ _____	❑ Financial ❑ Dental Information_____ _____
❑ Dentist (provide Name and Phone number) _____ _____	❑ Results of X-rays, lab tests, treatment planned, etc. ❑ Dental Information_____ _____
❑ Dental Insurance (provide Name and Phone number) _____ _____	❑ Financial ❑ Dental Information_____ _____
❑ Other (provide Name and Phone number) _____ _____	❑ Financial ❑ Dental Information_____ _____

PATIENT INFORMATION

I understand that I have a right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 federal or state law.

I understand that my dental care and payment for my health care will not be affected if I do not sign this form.

I understand that I have a right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
This authorization shall remain in effect until revoked by the patient in writing.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

The Notice of Privacy Practices is available in the lobby of the facility. I have reviewed Thomas A. Copulos, D.D.S.,P.A. Notice of Privacy Practices. I understand that I may request a copy of the Privacy Practice at any time.

_____ _____
Signature of Patient/Patient's Representative Date

_____ _____
Printed name of Patient/Patient's Representative Relationship to Patient

Thomas A. Copulos, D.D.S., P.A.

Notice of Privacy Practices

This Notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We are required to keep your health information secure and confidential, by law. Also by law, we need to give you this Notice and to follow the terms of this Notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, for quality assessment and improvement activities, conducting training programs, and licensing activities.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call, text, or email and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner. Your health information will not be sold in any other manner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this Notice.

If we change any of the details of this Notice, we will post the new Notice clearly and prominently at our practice location, on our website, and we will provide copies of the new Notice upon request

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact Ruth Morsel at drtcopulos@aol.com for more information, to make a request, to file a complaint with us, or for assistance regarding your health information privacy.

I acknowledge that I have received the Notice of Privacy Practices of Thomas A. Copulos, D.D.S., P.A.

Signature of Patient or Representative _____Date_____

Print Patient Name _____DOB:_____