PATIENT INFORMATION
CONFIDENTIAL

FIRST NAME:_____ MI:_____ LAST NAME:_____
STREET ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
HOME PHONE:_____ CELL PHONE:_____
SS#:_____ BIRTHDATE:_____
SEX:_____ MARITAL STATUS:_____
EMPLOYER:_____ WORK PHONE:_____
IS THIS PATIENT INSURED?:_____ INSURANCE COMPANY:_____

RESPONSIBLE PARTY INFORMATION

FIRST NAME:_____ MI:_____ LAST NAME:_____
STREET ADDRESS:_____
CITY:_____ STATE:_____ZIP:_____
HOME PHONE:_____ CELL PHONE:_____
SS#:_____ BIRTHDATE:_____
SEX:_____ MARITAL STATUS:_____
EMPLOYER:_____ WORK PHONE:_____
RELATIONSHIP TO PATIENT:_____

SPOUSE OR OTHER PARENT'S INFORMATION

FIRST NAME:_____ MI:_____ LAST NAME:_____
STREET ADDRESS:_____
CITY:_____ STATE:_____ZIP;_____
HOME PHONE:_____ CELL PHONE:_____
SS#:_____BIRTHDATE:_____
SEX:_____ MARITAL STATUS:_____
EMPLOYER:_____ WORK PHONE:_____

EMERGENCY CONTACT
(NEAREST RELATIVE NOT LIVING WITH YOU)

NAME:_____ _____ PHONE:_____
ADDRESS:_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

FAMILY MEMBER FRIEND PHONE BOOK INSURANCE COMPANY
OTHER:_____

RONALD W. SPENCER, D.D.S., P.C.
207 SOUTHDOWN DRIVE
MARYVILLE, TN 37801
Phone (865)983-5451
Fax (865)681-6113
spencerdental@charter.net

Date:_____

Patient Name:_____

Dentist's Name: _____

I hereby request the release of my records and x-rays to:

Ronald W. Spencer, D.D.S., P.C.
207 Southdown Drive
Maryville, TN 37801

In accordance with Tennessee State Law T.C.A.63-2-101(a)(10) that states "a copy of the patients dental records must be released to the patient or the patient's authorized representative within 10 working days upon request in writing."

Signature:_____

MEDICAL HISTORY

Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
Height: _____ Weight: _____ Cell or Work Phone: _____
Physician_____ Office Phone_____ Date of last exam_____

Answer all questions by circling Yes (Y) or No (N). **All responses are kept confidential.**

1. Are you in general good health at this time? ....Y N
2. Are you under any medical treatment now? ....Y N
3. Have you had any serious illnesses, operations or hospitalizations? …….....Y N
   If yes please list.

_____
_____

4. **Do you have or have you ever had:**
   A. A Heart Ailment? .....……Y N
   B. High Blood Pressure?.....Y N
   C. Respiratory Disease?. .....Y N
   D. Diabetes? ……..Y N
   E. Rheumatic Fever? ……Y N
   F. Rheumatism or Arthritis? ……Y N
   G. Tumors or Growths? ..... Y N
   H. Blood Disease? ….……....Y N
   I. Liver Disease, Jaundice or Hepatitis?..... Y N
   J. Kidney Disease? ……..……...Y N
   K. Stomach or Intestinal Disease? …… Y N
   L. Venereal Disease? ……Y N
   M. HIV+/AIDS? ……Y N
   N. Epilepsy? ……...Y N
   O. Implants placed anywhere in your body? ..Y N
   P. Psychiatric or Emotional Disorder? ……. Y N
   Q. Alcohol or Chemical Dependency?.....Y N
   R. Head Injuries? ……....Y N
5. **Are you now using any of the following**:
   A. Antibiotics?..……..Y N
   B. Anticoagulants (Blood Thinners)?..……Y N
   C. Aspirin, Motrin, Aleve, Ibuprofen?.....Y N
   D. Blood Pressure Medication?.....Y N
   E. Steroids (Cortisone, Prednisone, etc.)? Y N
   F. Tranquilizers?.....Y N
   G. Insulin or Oral Anti-Diabetic drugs?.....Y N
   H. Digitalis, Inderal Nitroglycerin or other heart drug?.....Y N
   I. Other medications not listed above, including prescription, over-the-counter, diet, herbal, vitamins? (please list):

_____
_____
_____
_____

6. **Have you ever taken**:
   A. Pre-med before dental treatment?..... Y N
   B. Fosomax, Actonel, Didronel or Skelid for Osteoporosis?..... Y N
   C. Fen-Phen? ……Y N
   D. Chemotherapy or Radiation? ……..…… Y N
7. **Have you had any adverse or allergic reactions to**:
   A. Penicillin or other antibiotics?..... .....Y N
   B. Sedatives or Barbiturates?.....Y N
   C. Aspirin or Ibuprofen? ……Y N
   D. Codeine or other pain killers? ……Y N
   E. Metals or Jewelry?.....Y N
   F. Chemicals? ……. Y N
   B. Metals or Jewelry.....Y N
   G. Latex or Rubber Products ……..…Y N
   H. Food Products? ……...Y N
   I. Local Anesthesia (Novacain, etc.)?..……...Y N
   J. Other allergies or reactions? Please list:

_____
_____

8. Are you on a diet at this time? .....Y N
9. Have any wounds healed slowly or presented other complications? .....Y N
10. Are you pregnant or nursing? .....Y N
11. Do you have a history of fainting? .....Y N
12. Do you smoke or chew Tobacco? ……..Y N
    If yes, how much per day? _____

DENTAL HISTORY

13. **Do you or have you had**:
   A. Pain in or near your ears? .....Y N
   B. Injuries or inflamed areas in your mouth? ..Y N
   C. Any growths or sore spots in your mouth?..Y N
   D. Pain in your mouth when clenched? ……..Y N
   E. Any difficult extractions in the past? .....Y N
   F. Prolonged bleeding after an extractions?....Y N
   G. Bleeding Gums? .....Y N
   H. Chew on only one side of your mouth?.....Y N
   I. Habitually clench your teeth? .....Y N
   J. Sensitivity to pressures or irritants (cold, sweets)? ……...Y N
   K. Any dental complaints? .....Y N
14. When was your last full mouth X-RAY taken?
    _____Where?_____

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Signature: _____ **Date**: _____

OFFICE USE ONLY

Updated_____ Initials_____ Updated_____ Initials_____

Updated_____ Initials_____ Updated_____ Initials_____

RONALD W. SPENCER, D.D.S., P.C.
207 SOUTHDOWN DRIVE
MARYVILLE, TN 37801
Phone (865)983-5451
Fax (865)681-6113

PATIENT NAME:_____

_____ I authorize use of this form on all of my insurance submissions.

_____ I authorize release of information to all of my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

_____ I authorize payment directly to my doctor.

_____ I permit a copy of this authorization to be used in place of the original.

_____ My signature also applies to the dependents listed below.

Dependent's Name Birthdate

_____

_____

_____

_____

_____

Signature _____ Date _____

Ronald W. Spencer, D.D.S., P.C.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent
Name: _____
Address: _____
Telephone: _____ Social Security Number: _____

SECTION B: To The Patient – Please Read The Following Statements Carefully.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of you protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Stephanie Young Telephone: (865)983-5451 Fax: (865-681-6113)
Address: 207 Southdown Drive, Maryville, TN 37801

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf for the patient, complete the following:

Personal Representatives Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

****

Revocation of Consent: I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my consent.

Signature: _____ Date: _____

Ronald W. Spencer, D.D.S., P.C.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Ronald W. Spencer, D.D.S., P.C.
207 Southdown Drive
Maryville, TN 37801
(865)983-5451
Fax (865)681-6113

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement.****

I, _____, have received or have been offered a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

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

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (please specify).

_____

_____

_____

RONALD W. SPENCER, D.D.S., P.C.

FINANCIAL POLICY

We will try to work with all our patients and request our patients work with us by keeping the following policies that pertain to them when making an appointment. If you would like a copy of our policies for your records we will be happy to make one for you.

INSURANCE

Group insurance is an agreement between you and your insurance company, not between your insurance company and this office. As a courtesy to our patients, our office will complete any necessary forms and file them at no charge to you. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible for payment. It is required that each patient who wishes to file insurance through this office, pay the insurance policy's deductible and the co-pay percentage at the time of service as stated in your policy. When all insurance monies have been received, if there is any overpayment, we will refund this to you. We will file claims to most insurance companies but you are responsible to know your insurance information and what they cover in services. We **do not** accept HMO'S, discount plans or managed care policies.

DEPENDANTS

Both parents or guardians are responsible for the bill of your children or dependants. If insurance is involved you must furnish this office with the necessary information to file the insurance. In cases of divorce or separation, both parents are responsible for the bill. This office can not send separate bills to each parent.

NO INSURANCE

We request that 100% of the first visit be paid at the time of the first visit. You may discuss other financial arrangements after treatment has been determined. We offer 6 to 12 months no interest payments through CareCredit with approved credit. We also accept VISA, Mastercard and Discover. There is a fee of $25 added to your account for any returned checks.

ON THE JOB INJURY

Worker's comp usually pays in full for services rendered. A 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this period, or if you have suspended or terminated treatment with this office, payment for services are due immediately.

COLLECTIONS

We can not maintain unpaid accounts in our practice. Your account, if delinquent, is subject to a billing charge of $50 and 2% monthly interest. Once placed with our collection agent charges of 50% will be added plus any necessary attorney fees.

APPOINTMENTS

There is a $50 fee for missed appointments. 24 hours notice is required if appointments must be cancelled or rescheduled.

I have read, understand and agree to the above stated financial policies of Ronald W. Spencer, D.D.S., P.C.

_____ _____

Signature Date

_____

Witness

Eff. 8/1/2011