RICHARD L. SPENCER DDS

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Welcome to our Practice

Today's Date: * _____

A response is required for all sections. Please fill out the following as thoroughly as possible. If something does not apply to you then please respond with N/A.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* ___ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____*
City State Zip Code

Person Responsible for Account

The following is for:* ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____* _____* ___ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ○ Male ○ Female **Family Status:*** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____*
City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact: *

_____

_____

Employment Information

The following is for:* ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name:* _____ **Phone:** _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Do you have Dental Insurance? If yes, please provide the requested information below. If no, please respond below with N/A. *

○ Yes ○ No

Primary Dental Insurance:

Name of Insured: _____* _____* ___

Last First MI

Patient's relationship to insured:* ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:* _____

Insured's Date of Birth: _____

Member ID: _____

Insurance Mailing Address:

○ Check here if you do NOT have insurance and respond below with N/A to the following

○ Check here if you have insurance and fill out below where the claims should be mailed (This can be found on the back of your insurance card)

Address: _____* _____

Address 1 Address 2

_____* _____* _____* _____-____

City State Zip Code

Insurance Company Phone Number: _____

Secondary Dental Insurance

Do you have Secondary Dental Insurance? If yes, please provide the requested information below. If no, please respond below with N/A. *

○ Yes ○ No

Name of Insured: * _____ * _____ ___
Last First MI

Patient's relationship to insured:* ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:* _____

Insured's Date of Birth: _____

Member ID: _____

Insurance Mailing Address:

○ Check here if you do NOT have secondary insurance and respond below with N/A to the following

○ Check here if you have secondary insurance and fill out below where the claims should be mailed (This can be found on the back of your insurance card)

Address: * _____ _____
Address 1 Address 2

_____ * _____ * _____-_____ *
City State Zip Code

Insurance Company Phone Number: _____

Insurance Authorization:

☐ ***By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Allergy Aspirin
- ☐ Allergy Cefalexin
- ☐ Allergy Clindamycin
- ☐ Allergy Codeine
- ☐ Allergy Epinephrine
- ☐ Allergy Keflex
- ☐ Allergy Latex
- ☐ Allergy NSAIDS
- ☐ Allergy Other
- ☐ Allergy Penicillin
- ☐ Allergy Sulfa
- ☐ Allergy Tylenol 3
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fluoride
- ☐ Glaucoma
- ☐ Growths
- ☐ HIV/AIDS
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replace
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hydralizine
- ☐ Infection (Pre-Med)
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Lidocaine
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Pro
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Vertigo

Please clarify any conditions or alerts selected if needed or add if not listed: *

_____

_____

Allergies not listed: *

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ○ Yes ○ No

Pre-Med: * _____

Preferred Pharmacy and Phone Number: *

_____

_____

Are you currently taking any medications (prescription and non-prescription)? If yes, please list medications and dosages below. If no, please respond N/A: *

○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

_____

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)
Name, Phone Number, and Relationship to Patient: *

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

If filling out form in person or in office please sign to authorize your paperwork and acknowledge that you have read the above information, filled it out to the best of your ability, and agree to all conditions and content from the form. Thank you!

Signature _____ **Date** _____

Response Date: _____