Spouse or Responsible Party:

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Name: _____

Date of Birth: _____

Social Security #: _____

Driver's License #: _____ State: _____

❑ Male ❑ Female

❑ Married ❑ Single ❑ Child ❑ Other

Address: _____

_____

_____

Phone: _____

Cell: _____

Email: _____

Employment Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ Phone: _____

Insurance Information:

Full Legal Name of the Insured: _____ Is the insured a patient?: ❑ Yes ❑ No

Insured Date of Birth: _____

Name of Insurance Company: _____

Contract ID#: _____

Group #: _____

Patient's relationship to insured:

❑ Self ❑ Spouse ❑ Child ❑ Other

Phone Number: _____

Insured's Employer Name & Address:

_____

_____

_____

Insured's Address:

_____

_____

_____

Please include a copy of your insurance ID card
Health Information

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Disease Bruise
- ❑ Easily Cancer
- ❑ Cold Sores/Fever
- ❑ Blisters
- ❑ Contact Lenses
- ❑ Cortisone Medication
- ❑ Diabetes
- ❑ Diet - Special
- ❑ Diet – Restricted
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ H. I. V. Positive
- ❑ Head Injuries
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Surgery
- ❑ Heart Murmur
- ❑ Hemophilia Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Sensitivity
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Psychological Care
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Smoking
- ❑ Chewing Tobacco
- ❑ Snoring
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Other:

_____
_____
_____
_____
_____

Are you pregnant? ❑ Yes ❑ No
When is your due date? _____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No
If Yes, please explain:

Have you ever been hospitalized or needed surgery? ❑ Yes ❑ No
If Yes, please explain:

Are you now under the care of a physician? ❑ Yes ❑ No
Who is your physician?

Do you have any health problems that need further clarification? ❑ Yes ❑ No
If Yes, please explain:

List the **medications** that you are currently taking. Please include:

- Prescriptions
- Non-prescriptions
- Over the counter
- Vitamins
- Oral contraceptives
- Any other medications

_____
_____
_____
_____
_____

List the medications that you are **allergic** to:	_____ _____
Do you **grind** your teeth?	☐ Yes ☐ No
Is your bite comfortable when **chewing or biting**?	☐ Yes ☐ No
Do you have frequent **headaches**?	☐ Yes ☐ No
Do you have any old **fillings** or dental treatment that you are **unhappy with**?	☐ Yes ☐ No
Do you have **Sleep Apnea**, been prescribed a **CPAP**, have trouble **snoring** or any other problems sleeping?	☐ Yes ☐ No
Do you have problems with **bad breath**?	☐ Yes ☐ No
Is there anything about your **smile** that you do not like?	☐ Yes ☐ No
Are all of your **teeth** in **alignment**?	☐ Yes ☐ No
Do you have any **missing teeth**?	☐ Yes ☐ No
Are any **teeth chipped**?	☐ Yes ☐ No
What would you like to **change** the most about the **appearance of your teeth**?	
Are you interested in a free **cosmetic** consultation?	☐ Yes ☐ No
Is there **anything else** you would like to discuss with **Dr. Spink**?	☐ Yes ☐ No Please Describe: _____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and 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.

Patients who carry dental insurance understand that all dental services furnished 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 such 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.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signed:

_____	_____	_____
Signature of Patient or Guardian	Date	Relationship to Patient

_____	_____	_____
Signature of guarantor of payment/responsible party	Date	Relationship to Patient

SPINK DENTISTRY
general + cosmetic

Spink Dentistry
4005 Crosshaven Drive
Birmingham, AL 35243
Phone: 205-967-8555
Fax: 205-968-0202
beth@spinkdentistry.com

I _____ give permission for Spink Dentistry to discuss my dental conditions/information with the following:

Example: spouse, parents, children, friend

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient or Guardian Date

*This is to be completed by patients with **Blue Cross and Blue Shield of Alabama** <u>only</u>.*

NON-COVERED SERVICES WAIVER FORM

Before services are rendered, this form must be signed.

I, _____, agree to accept full
(Beneficiary or Beneficiary's Legal Guardian)

responsibility for dental care provided by Bruce T. Spink, D.M.D., P.C.

Should my insurance plan fail to pay for service, I agree to pay 100% of the fees.

_____ _____

Beneficiary's Signature (For minor's – Legal Guardian's Signature) Date

BRUCE T. SPINK, D.M.D., P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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

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, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 31, 2003, 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 such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our 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.

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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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, counterintelligence, 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, emails, postcards, or letters).

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).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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).

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. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints: If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about your privacy practices, you can contact our Privacy Officer, Beth White, at 4005 Crosshaven Drive, Birmingham, AL 35243. You may also submit a written complaint to the US Department of Health and Human Services. Your treatment within this office will not be affected by such a complaint.

SPINK DENTISTRY
general + cosmetic

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4005 Crosshaven Drive
Birmingham, AL 35243
Phone: 205-967-8555
Fax: 205-968-0202
beth@spinkdentistry.com

BRUCE T. SPINK, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

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

_____
Please Print Name

_____
Signature

_____
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 acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____