



# SPINK DENTISTRY

*general + cosmetic*

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

## Spink Dentistry New Patient Questionnaire:

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Male  Female

Married  Single  Child  Other

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_

What is the estimated date of your last visit? \_\_\_\_\_

### What brings you to us today? (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <b>General check-up</b> | <input type="checkbox"/> Toothache       | <input type="checkbox"/> <b>Veneers</b>               |
| <input type="checkbox"/> Cavity or Filling       | <input type="checkbox"/> Implant         | <input type="checkbox"/> Crown or Bridge              |
| <input type="checkbox"/> <b>Clear Aligners</b>   | <input type="checkbox"/> Zoom! Whitening | <input type="checkbox"/> <b>Night Guard</b>           |
| <input type="checkbox"/> Cosmetic Consult        | <input type="checkbox"/> Teeth Grinding  | <input type="checkbox"/> <b>Sleep Apnea (Snoring)</b> |
| <input type="checkbox"/> Other: _____            |  |   |

How were you referred to our practice?

- Sleep Birmingham Website
- Search Engine: \_\_\_\_\_
- Another patient, friend: \_\_\_\_\_
- Another doctor: \_\_\_\_\_
- Another dental office: \_\_\_\_\_

### 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:**

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

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  
shannon@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** only.*

## 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*

**Spink Dentistry**  
4005 Crosshaven Drive  
Birmingham, AL 35243  
Phone: 205-967-8555  
Fax: 205-968-0202  
shannon@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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_