Patient Name:_____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip:_____
Home:_____ Cell:_____ Best number to reach you at?_____
SS#:_____ E-mail: _____

Name of medical doctor:_____ Phone number: _____
Name of previous Dentist:_____ Phone number: _____
Name of Cardiologist: _____ Phone number: _____
Name of orthodontist: _____ Phone number: _____

MEDICAL HISTORY

Do you have, or have you ever had any of the following-Please check yes or no.

Y	N		Y	N		Y	N	
___	___	Allergies to drugs(list below)	___	___	Excessive Bleeding from cuts or extractions, Von Willebrand	___	___	Pacemaker or Defibrillator
___	___	**Artificial Joints or Valve**	___	___	Liver Disorder	___	___	Kidney Disease
___	___	**Allergy to Latex**	___	___	Hepatitis A, B,C	___	___	High/Low blood pressure
___	___	**Heart Attack**	___	___	HIV or AIDS	___	___	Stroke
___	___	**Cancer or Tumor**	___	___	Epilepsy or Convulsions	___	___	Rheumatic Fever
___	___	**Heart Valve Replacement**	___	___	Neurological problems or seizures	___	___	Radiation Treatments
___	___	Allergy to shellfish	Type of Seizures_____			___	___	Thyroid problems
___	___	Allergies to Anesthetics	___	___	Arthritis	___	___	Recurrent infections of any kind
___	___	Allergy to IV dyes (iodine)	___	___	Mental Health Problems	___	___	Ulcer, Colitis, Reflux Disease
___	___	Allergy to eggs	___	___	Alzheimer's or Dementia	___	___	Tuberculosis
___	___	Heart Murmur	___	___	Anxiety or Depression	___	___	Diabetes
___	___	Mitral Valve Prolapse	___	___	Autism	___	___	Insulin Dependent
___	___	Asthma	___	___	Mental Retardation	___	___	Glaucoma
___	___	Sleep Apnea or Snoring	___	___	Clicking or popping of Jaw joint	___	___	Currently taking blood thinners
___	___	Nasal or Sinus Problems	___	___	Difficulty opening mouth or Grind or Clench teeth	___	___	Are you pregnant? If so, what month? _____
___	___	Seasonal Allergies				___	___	Are you nursing?
___	___	ADHD or ADD						
___	___	Dry Mouth	___	___	Severe Headaches			

Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancer? □ YES □ NO
(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) _____

Do you smoke/chew tobacco? _____ How much? _____ Alcohol? _____ How much? _____

Do you use (even casually) Marijuana or Street Drugs? (Strictly confidential) _____ How much? _____

Do you have any allergies not listed above? (If so, please list)_____

Please list all surgeries. _____

Please list all medical disorders. _____

Please list **ALL** medications you are currently using, including Prescription Medications, Herbal Medications, Vitamins and Over the Counter medication. _____

Reason for your visit today _____

Date_____ Signature _____

Michael J. Spence DMD Dental
Financial Policy

Welcome to our office! We are happy to have you as our patient and thank you for selecting us as your dental health care provider. Please read over the following and feel free to ask any questions that you may have. We will do our best to answer your questions for you.

FOR OUR PATIENTS WITHOUT INSURANCE:

- The fee for treatment rendered must be paid in **FULL** on the day of service. **There is a 10% cash discount if paid in full by check or cash. No discount will be given for payment by credit or debit card. This discount only applies to our patients WITHOUT any insurance coverage.**

FOR OUR PATIENTS WITH INSURANCE COVERAGE:

- Your insurance policy is a contract between you and your insurance company. Insurance is **not** a guarantee of payment; it often does not cover all the costs involved with treatment.
- The insurance companies that we participate with are:
  - Cigna DPPO
  - Delta Dental **Premier**(not PPO)
  - United Concordia (National Fee For Service-please check with your insurance company)
  - UPMC Dental Advantage(does not apply to UPMC for Life Medicare-we are not in network with Medicare based plan)
- We will bill your insurance for you. You are responsible for the **DEDUCTIBLE and ESTIMATED CO-PAY at the time of service.** If you are unable to pay your deductible and estimated co-pay at the time of service, please notify the front desk immediately so that we may reschedule your appointment for you. If your insurance company does not pay their portion after 45 days, we will bill you directly for the full balance.
- Patients with insurance coverage do not qualify for the cash discount. That is only for the patients without any insurance.
- Please let our front desk know of any insurance changes when checking in.

FOR YOUR CONVENIENCE WE ACCEPT:

- Cash
- Check
- Mastercard, Visa, Discover, Debit Cards
- Care Credit-a financing option

MISSED/NO SHOW/EXCESSIVE CANCELLATION POLICY

Appointments are reserved exclusively for you. We require a 24-hour notification if you must change/cancel an appointment. This makes it possible for us to give your reserved time to another patient who is on our waiting list, or is in need of an emergency appointment.

There will be a **$75.00 charge** for missed or last-minute cancellations for scheduled appointments that will be due before rescheduling your appointment. Repeatedly missing or cancelling appointments will result in loss of future appointment privileges.

I have read and understand this financial policy.

_____	_____	_____
(Printed Name)	(Signature)	(Date)

MICHAEL J. SPENCE, DMD PRIVACY NOTICE
Effective April 24, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: Michael J. Spence, DMD is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of the practice. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. Michael J. Spence, DMD may also use personal health information to carry out day to day operations such as scheduling, quality review and appointment reminders. A list of other examples of disclosures can be obtained from the Privacy Officer upon request.

Required Authorizations: Michael J. Spence, DMD will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Michael J. Spence, DMD has adopted privacy policies regarding usage of patients' personal health information. Michael J. Spence, DMD is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.

Additional Information: For additional information regarding this office's privacy policy or for a copy of this notice, please contact the office. Michael J. Spence, DMD reserves the right to change this notice and to make the revised and changed notice effective for medical information that the office already has about you, as well as any information the office receives in the future.

The following signature acknowledges that I have **RECEIVED** a copy of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations. _____

The following signature acknowledges that I have **DECLINED** a copy of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations, but I have read my rights above._____