Wood, Spooner & Mills
Cosmetic and General Dentistry
502 Montgomery Hwy, Ste 201
Birmingham, Al 35216

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell#: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Cell#: _____

Home Phone: _____ Work Phone: _____ ☐ I would like to receive correspondences via text message.

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired Occupation _____

Student Status: ○ Full Time ○ Part Time

Carrier ID: _____ Employer ID: _____

Pref. Pharmacy: _____ Phone: _____

Spouse's name: _____

Who may we thank for referring you to our office?

_____

Emergency Contact: Name _____ Phone _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

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Phone 205.822.2808 Fax 205.822.2626

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No Do you use controlled substances? ◯ Yes ◯ No
Have you ever taken Fosamax, Boniva, Actonel or any other medication that contains bisphosphonates? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sleep Apnea/CPAP ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental Insurance Information

FINANCIAL POLICY
AND AGREEMENT

Thank you for your support by allowing us to provide your dental care. To clarify our billing procedures, our financial policy is outlined below:

1. **Payment is due at the time the service is rendered** unless financial arrangements have been made with the financial coordinator. We accept cash, checks, Visa, MasterCard and American Express. CareCredit is offered as an option for extended payment. Our financial coordinator will help explain this method of financing.

2. **Insurance** - Insurance should be viewed as an aid in helping make dental treatment affordable. Dental insurance generally will not pay 100% of the services and the patient will have a deductible and/or co-payment that they are responsible for paying. Insurance plan benefits and payment percentages are decreasing and the amount that patients are responsible for is therefore, increasing. Secondary insurance plans are no longer guaranteed due to a clause called non-duplication of benefit; therefore, our office does not file secondary claims. There are also instances when insurance plans will not cover a particular service or will pay for a lesser service. Patient is responsible for any deductibles, copays and any Non-covered services at our usual customary rates.

a. Please **bring your insurance card** and any insurance information you have. This will help us estimate your benefits.

b. **Co-payments and deductibles are due on the date of service**. We will estimate (or predetermine on larger cases) the co-payment amount and make payment arrangements prior to treatment. The patient is responsible for any balance that the insurance does not cover. Pretreatment Estimates by the insurance company are not guarantees of payment and the patient is responsible for unpaid balances.

c. **We will file your insurance as a courtesy and follow-up on delayed claims for 45 days.** After this time period, **any unpaid balance is the responsibility of the patient**. Insurance is a contract between the employer, the insurance company, and the patient. Problems that extend beyond 45 days should be taken up with your human resources director at your place of employment.

3. We employ a 48-hour cancellation policy. We reserve the right to charge a fee for broken appointments without sufficient notice.

I hereby authorize the release of any dental or medical information and assign all insurance benefits to Drs. Diana P. Wood, Melanie H. Spooner and Lindsey R. Mills. I understand that I am financially responsible to the dentist for all of my family's individual charges incurred during the course of treatment, even thought I may have insurance or other third party coverage. I promise to pay this amount when due. In event of default and this account is placed with a third party collection agency, I agree to pay add on collection charges in the amount of 33.33% of the unpaid balance. In the event of default, I recognize that legal proceedings may result and I agree to pay all costs of collection, including reasonable attorney's fees. I understand that certain insurance carriers require referral to see a specialist for treatment. I understand it is my responsibility to secure this authorization. It is understood that if any claim is denied or rejected as non-covered by my insurance carrier that it my responsibility to pay. **I understand that if my dental claim is not paid within 45 days of filing, I am responsible for payment in full and will have to seek reimbursement from dental insurance company.** I also understand that if I have a second dental insurance carrier, I am responsible for filing that claim with the information provided from Drs. Diana P. Wood and Melanie H. Spooner office to seek reimbursement.

I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY:

Patient Name: _____ Date: _____

Signature of Patient or Guardian: _____ (Agrees to pay) Date: _____

Signature of Financial Coordinator: _____ Date: _____

Signature: _____ Date: _____

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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.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (please specify):

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Smile Analysis

Last Name _____ First Name _____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit ? _____/_____/_____ Date of last dental xrays?_____/_____/_____

2. Reason for last visit?_____

3. Do you have any concerns about previous dental care or this dental visit? _____

4. On a scale of 1 to 10 (10 being the highest), how important is it for you to keep your teeth for the rest of your life? _____

5. Are you happy with your smile? (circle your response) Yes No

   If no, please explain _____

6. Do your gums bleed? Yes No

7. Are your teeth loose? Yes No

8. Have you ever been told you have bad breath? Yes No

9. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure

10. Do you like the color of your teeth? Yes No

11. Do you feel your teeth are starting to get longer? Yes No

12. Do you get food stuck between your teeth easily? Yes No

13. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No

14. What would you change about the condition of your mouth? _____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers that I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ Date_____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient:

Print Name _____ Relationship _____

Signature _____ Date_____