QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Kathryn Spencer   Phone: 615-942-7811   Email:coolspringsdentistry@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of Cool Springs Dentistry's Notice of Privacy Practices.

I, the undersigned, hereby agree that, in the event of default in the payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred. I give permission to be contacted by Cool Springs Family Dentistry or a 3rd party by cell phone with billing and collections issues.

____

(Please Print Name)   (Date)

____

(Signature)

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 prohibited us from obtaining the acknowledgement
- ☐ Other (Please Specify)

COOL SPRINGS DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:____

Telephone:_______________________________ **Email:**___________________________________

Social Security Number:____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of out Notice accompanies this Consent. We encourage you to read it carefully and complete before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. if we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Attn: Dr. Kathryn Spencer
Phone: 615-942-7811 Fax: 615-942-7609
Email: coolspringsdentistry@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:____ Date:____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Cool Springs Dentistry

Kathryn Spencer, D.D.S.

Patient Information (Confidential)

Date_____________

Name__________________________________ Birthdate_______________SS#____________________

Address_________________________________ City__________________ State_________ Zip___________

Home Phone(_____)_____________Cell Phone(_______)_____________ Email_____________________________

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College/University:____

Patient or Parent/Guardian's Employer_________________________________Work Phone_______________

Spouse or Parent/Guardian's Name____________________ Employer____________Work Phone______________

Whom May We Thank for Referring You?____

Person to Contact in Case of Emergency________________________________ Phone____________________

Pharmacy of Choice______________________Address____________________Phone_____________________

Responsible Party (If other than self)

Name of Person Responsible for this Account________________________ Relationship to Patient_______________

Address____ Home Phone______________________

Email____ Cell Phone_______________________

Birthdate__________________SS#_________________________ Driver's License #______________________

Is This Person Currently a Patient in our Office? ❑ YES ❑ NO

For your convenience we offer the following methods of payment. Please Check the option you prefer.

Payment in full at each appointment. ❑ Cash ❑ Personal Check ❑ VISA ❑ Master Card ❑ Discover

❑ I wish to discuss the offices' payment policy

Insurance Information

Name of Insured____ Relationship to Patient_______________

Birthdate__________________SS#_________________________ Date Employed______________________

Name of Employer____ Work Phone____________________

Address of Employer______________________ City____________________ State___________ Zip__________

Insurance Company_______________________ Policy ID#__________________ Group #__________________

Insurance Company Address____________________ City______________ State___________ Zip__________

Do You Have Additional Insurance? ❑ YES ❑ NO If Yes, Complete Following:

Name of Insured____ Relationship to Patient_______________

Birthdate__________________SS#______________________ Date Employed__________________________

Name of Employer____ Work Phone____________________

Address of Employer______________________ City____________________ State___________ Zip__________

Insurance Company_______________________ Policy ID#__________________ Group #__________________

Insurance Company Address________________ City__________________ State___________ Zip__________

Patient Medical History

Physician________________________________ Office Phone___________________ Date of Last Visit_______________

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for any surgical operation or serious illness within the last five years? If Yes, please explain________________________ ____________________________________	❑	❑
3. Are you taking any medication(s) including non-prescription drugs?	❑	❑
If YES, what are you taking?___________ ____________________________________		
4. Have you ever taken Fen-Phen/Redux?	❑	❑
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	❑	❑
6. Have you taken Viagra, Revoti, Cialis or Levitra in the last 24 hours?	❑	❑
7. Do you use tobacco?	❑	❑
8. Do you use a controlled substance?	❑	❑
9. Are you wearing contact lenses?	❑	❑
10. Are you allergic or do you have any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (Nickel, Mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)___________________		
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 5 weeks)?	❑	❑

	YES	NO
12. *Women only:*		
a) Are you pregnant or think	❑	❑
you may be?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking contraceptives?	❑	❑
13. Do you have or have you had any of the following?		
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑
AIDS or HIV Infection	❑	❑
Thyroid Problem	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmer	❑	❑
Angina	❑	❑
Stomach troubles/Ulcers	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Arthritis	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Allergies/Hay Fever	❑	❑
Tuberculosis	❑	❑
Liver Disease	❑	❑
STD	❑	❑
Hepatitis/Jaundice	❑	❑
Glaucoma	❑	❑

Patient Dental History

Name of Previous Dentist and Location________________________________ Date of Last Visit______________

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot/cold liquids/food?	❑	❑
3. Are your teeth sensitive to sweet/sour liquid/food?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in	❑	❑
or near your mouth?	❑	❑
6. Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain	❑	❑
Difficulty in opening/closing?	❑	❑
Difficulty in chewing?	❑	❑
7. Have you ever had any head, neck or jaw injuries?	❑	❑

	YES	NO
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips/cheeks often?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding from extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials?	❑	❑
15. Have you received oral hygiene?	❑	❑
16. Do you like your smile?	❑	❑

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ ________________

Signature of Patient *(or parent or guardian if a minor)* Date

Doctor's Comments____

____

____

____

Signature____ Date_______________