SPEARS DENTAL
Jared L. Spears DDS PC
77 Smithson Drive, PO Box 396, Cassville, MO 65625 Phone: (417) 847-2461 Fax: (417)-847-4005

MINOR PATIENT INFORMATION

How did you hear about our office? _____

Date: _____ Patient Name:_____ Preferred Name:_____

Date of Birth:_____ Social Security # :_____ M / F

Phone (Home) _____ (Parent cell)_____ (Patient cell)_____

Mailing Address: _____
Street City State Zip Code

Parent/Guardian:_____ School:_____

Parent/Guardian E-mail Address:_____

Have you ever had any of the following? **Please circle Y or N to each description**

Y N Medication Allergies	Y N Cancer	Y N High Cholesterol	Y N Rheumatic Fever
Y N Latex Allergy	Y N Chemotherapy	Y N HIV/AIDS	Y N Sleep Apnea
Y N Blood Thinner	Y N Diabetes A1C:	Y N Jaundice	Y N Snoring
Y N Bone Density Meds	Y N Epilepsy	Y N Kidney Disease	Y N Stents
Y N Artificial Joints (list w/date)	Y N Excessive Bleeding	Y N Liver Disease	Y N Stroke
	Y N Fainting/Dizziness	Y N Mental Disorders	Y N Systemic Diseases
Y N Acid Reflux	Y N Fluoride in Water	Y N MVP mitral valve	Y N Thyroid Problems
Y N Anemia	Y N Glaucoma	Y N Nervous Disorders	Y N TMJ Problems
Y N Appetite Suppressants	Y N Head Injury	Y N Pacemaker	Y N Tobacco Usage
Y N Arthritis	Y N Heart Disease	Y N Currently Pregnant/Due:	Y N Tuberculosis
Y N Aspirin Daily 81 / 325	Y N Heart Murmur		Y N Tumors/Growths
Y N Asthma	Y N Hepatitis	Y N Radiation	Y N Ulcers
Y N Blood Disease	Y N High Blood Pressure	Y N Respiratory Problems	Y N Venereal Disease

List all Allergies:_____

Have you ever had a reaction to any medication? Explain:_____

List Medication/Supplements taking now:_____
(or we can scan your list)

Are you now under the care of a physician? Explain:_____

Has a physician/surgeon advised the need for antibiotic Pre-Med prior to dental treatments? Yes_____ No_____

Do you have any health problems that need further clarification? Yes _____ No _____

Physician's Name:_____ City:_____ Phone:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Payment/Insurance Policy: We require payment in full at the time of service, less any insurance reimbursement, if applicable. Each patient, not his/her insurance company, is responsible for any payment due to this office. As a courtesy we will bill your insurance. Regardless of any disputed or pending claim, if there is an open balance, you are liable for this and prompt payments is expected. I authorize payment of dental insurance benefits directly to Jared L. Spears DDS PC

Parent/Guardian Signature: _____ Date: _____

Insurance Co :_____ Phone:_____

Plan #: _____ Policy Holder: _____

Policy Holder's SS#: _____ Policy Holder's DOB:_____

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PATIENT QUESTIONNAIRE

Patient Name:_____ _____

We want you to have a great experience in our office. In order to help make you as comfortable as possible, we would like to ask you a couple of questions.

1. Have you ever had a bad experience in a dental office? Yes_____ No_____
   If yes, how old were you? _____
   Can you briefly tell us what happened?
   _____
   _____

2. Do you have a fear of:

___ Injections	___ Being Confused	___ Dentures
___ Drilling Procedures	___ Extractions	___ Bleeding
___ Having your teeth criticized	___ Numbness	___ Infection
___ Gagging	___ Swelling	

___ Other _____

3. Do you have any teeth that are sensitive to hot, cold, sweets or biting pressure?
   _____

4. Do you clench or grind your teeth?_____
5. Do you get headaches often?_____
6. Would you like your teeth to be: _____ Straighter _____ Whiter
7. Have you whitened your teeth in the past? ____ Yes ____ No
8. Do you have any special needs we should address? _____
   _____

CANCELLATION POLICY

We recognize how very valuable your time is, therefore, our office policy is to schedule as effectively as possible. A charge will be assessed per patient for each appointment that is not kept or is not given adequate twenty-four hours notice prior to cancellation. Notification of cancellation on the answering machine after working hours, over weekend, or on holidays will not be considered acceptable to avoid these charges as we do not receive these messages until the following normal business hours.

24-hour advance notice is necessary to cancel an appointment. It is our policy to assess a charge for inadequate notice of cancellation.

Signature: _____ Date: _____

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HIPPA FORM

Patient Name:_____ Date of Birth:_____

1. Acknowledgement of Practice Notice of HIPPA Privacy

I understand, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A copy of the Notice of Privacy Practices is available containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this office an any time to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

2. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain portions of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply): ____ Phone ____ Written ____ Fax

Phone # :_____ (___cell or ___ home)

☐ Ok to leave message with detailed information

☐ Leave message with call back numbers only

Work Phone #: _____

☐ Ok to leave message with detailed information

☐ Leave message with call back numbers only

Written Communication

☐ Ok to mail to my home address only

☐ Ok to mail to my work/office address

Fax Communication

☐ Ok to fax to this number:_____

☐ Other

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. The persons below will only have contact with the Practice upon my request (i.e. if I ask the persons below to call the office or I contact the office and ask that the persons below to be contacted). I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. The following person(s) are not authorized to receive my patient health information:

Name:_____ Name:_____

By signing below, I have read and understood all the above information.

_____ _____ _____

Print Name of Patient/Parent/Guardian Signature Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Acknowledgement, but was unable to do so as documented below. A copy of the Notice of Privacy Practice has been given to the patient..

Date:_____ Initials:_____ Reason:_____