RIVERSIDE DENTAL

Michael D. Spencer, D.D.S. **Steven C. Ferber, D.D.S.**

PERSONAL INFORMATION

Today's Date___/___/____
Patient's Name:_____
Preferred Name:_____Male___Female__
Birthdate:____/____/____ Age:____ SS#_____
Mailing Address:_____
_____
Home Phone#:_____
Work Phone#:_____
Cell Phone#: _____

Email Address:_____
Referred by:_____
Employer:_____How Long:_____
Employer's Address:_____
Occupation:_____

Spouses Name:_____

INSURANCE INFORMATION

Primary Dental Insurance

Company's Name:_____
Address: _____
_____
Phone #: _____
Insured SSN: _____
Group #: _____
Insured's Name: _____
Date of Birth:___/___/___ Relation: _____
Insured's Employer:_____

Secondary Dental Insurance

Company Name: _____
Address:_____
_____
Phone #:_____
Insured's SSN: _____
Group #: _____
Insured's Name: _____
Date Of Birth:___/___/___ Relation: _____
Insured's Employer: _____

ACCOUNT INFORMATION

Person Ultimately Responsible for Account
Name:_____
Relation: _____
Billing Address: _____
_____
SSN: _____
Driver's License #: _____
Work Phone #: _____

IN EVENT OF EMERGENCY

Who should we contact? _____
Relation:_____
Home Phone # :_____
Work Phone # :_____
Medical Doctor: _____
M.D. Phone #: _____

Payment Method: Cash___ Credit___

_____ ___/___/___
enter card # above **expiration date**

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signed_____ ***Date*** _____

PATIENT HISTORY

Is your general health good?_____ Y N
Are you under a physicians care now?_____ Y N
Have you had trouble with bleeding after surgery?_____ Y N
Have you had a reaction to any drug or local anesthetic?_____ Y N
Describe_____
Please list your current drugs and medications. _____

_____
Are you having any discomfort at this time?_____ Y N
Describe :_____
Do you ever have cold sores or fever blisters? _____ Y N
Are your teeth sensitive to heat and cold?_____ Y N
How often do you brush your teeth?_____Do you use dental floss? Y N
Do your gums bleed when brushing or flossing?_____ Y N
Have you ever had gum treatments/surgery?_____ Y N
Do you feel you have an unpleasant taste in your mouth?_____ Y N
Do you grind or clench your teeth?_____ Y N
Do you have pain in or around your ears?_____ Y N
Do you have unexplained headaches?_____ Y N
Do you have popping or clicking noises when you chew?_____ Y N
Do you have difficulty opening your jaw?_____ Y N
Would you like to improve anything about your teeth?

_____

MEDICAL HISTORY

AIDS	Y	N	High blood pressure	Y	N
Asthma	Y	N	Joint Replacement	Y	N
Arthritis	Y	N	Kidney Disease	Y	N
Cancer	Y	N	Liver Disease	Y	N
Diabetic	Y	N	Lung Disease	Y	N
Epilepsy/Seizures	Y	N	MitroValve Prolaspe	Y	N
Fainting/Dizziness	Y	N	Radiation Treatment	Y	N
Glaucoma	Y	N	Rheumatic Fever	Y	N
Hepatitis	Y	N	Stomach Ulcers	Y	N
Heart Disease	Y	N	Stroke	Y	N
Heart Murmur	Y	N	Thyroid Disease	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N
Heart Valve Surgery	Y	N	Pregnant now	Y	N

I authorize release of medical or other information necessary to process insurance claims. I authorize payment of medical and/or dental benefits to Riverside Dental.
Signed_____***Date***_____

I acknowledge I have read and /or received a copy of this office's **Notice of Privacy Practices.**
Signed_____***Date***_____

Assistance with Dental Insurance

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL INSURANCE: Your insurance is a contract between you, your employer , and the insurance company. We are not a party to that contract. We must emphasize that as dental care providers our relationship is with **YOU** not the insurance company. Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing and filing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by the insurance company. For this reason, you may receive a lower percentage than the reimbursement level indicated by your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is an **estimate** and is for reference only and should not be your only basis for proceeding with treatment. **We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you.** We will assist you in any way that we can . In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when determining your portion of the charges. We will gladly give you what you need to file your secondary claims yourself and the payments from your secondary insurance can be assigned to you. Once your primary carrier has paid, any difference will be due upon receipt of our statement . If for any reason, we have not received your insurance carrier's payment 45 days after the claim has been submitted, the remaining balance will be due and payable by you and subject to interest charges if not paid within 30 days. Thanks for your understanding.

Financial Agreement

As with most professional offices, full payment for services is expected at the time services are rendered. Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard, Discover, American Express, or other outside financing. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible for payment of past due balance, any interest due, all costs of collection, including attorney's fees.

Appointment Policy

We believe in optimum communication with our patients. Therefore, we would like all our patients to understand our appointment policy.

Our time is valuable and so is yours. Our commitment to you is:

We always try to make appointments that are convenient for you.

We will not ask you to make a schedule change unless it is absolutely necessary.

We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that we reserve time just for you when you make an appointment with us. We make every effort to make appointments for you that are as convenient as possible. Please be considerate and give us **48 hour** notice if you need to change an appointment. Your cooperation is greatly appreciated.

Important: If you ever feel your personal time has been abused, please inform our scheduling coordinator.

I have read and understand the above financial and appointment policies. I authorize this office to perform diagnostic procedures (examinations, xrays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatments needs. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

Patient, Parent or Guardian Signature_____Date_____

Michael D. Spencer, D.D.S.
Steven C. Ferber, D.D.S.
1061 Riverside Ave., Ste 101
Jacksonville, Fl 32204
904.355.5531

Riverside Dental

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 practices that are described in this Notice while it is in effect. This Notice takes effect (4/14/03), 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, effective for all health information that we maintain, including health information we created or received before we made the changes as provided by applicable law. 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.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other health care 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, 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 of 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 of 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, identify, or locate 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, 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 using our professional judgment disclosing only healthcare information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and 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, 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 using a form to request access. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1 for each page, $15 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.)

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 twelve-month period, we may charge you a reasonable, cost-based fee for 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 with 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 on 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 we 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 in 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 your 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 chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Suzanne Spencer Telephone: 904-355-5531 Fax: 904-791-9239
1061 Riverside Ave., Suite 101, Jacksonville, FL 32204