Welcome!

Sampson Dental Group and staff would like to thank you for the opportunity to care for you.

PATIENT INFORMATION

Name (First and Last) _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Birthdate _____ Age ____ Social Security Number _____ Marital Status _____ Spouse's Name _____

Home Phone _____ Cell Phone _____ Email _____

INSURANCE INFORMATION

Subscriber's Name _____ Relation to Patient _____ Subscriber's Social Security Number _____ Subscriber's Date of Birth _____

Insurance Company _____ Employer _____ Member ID _____ Group Number _____

Address to Send Dental Claims _____ Customer Service Phone Number _____

FEE POLICY

Please Initial Below:

___Patients are expected to pay for treatment as services are rendered. It is not our policy to send monthly statements. To aid you with meeting your dental needs we accept Check, Visa, Mastercard, Discover, and American Express. We also offer Care Credit and other financing options. Please inquire at the front desk.

____Patients with dental insurance are required to pay their deductible when applicable at their first visit. It is your responsibility to confirm that your treatment is covered under your insurance plan. The percentage not covered by insurance is expected at each visit. If you are not prepared to pay for your scheduled appointment, you will need to be rescheduled. We will submit your insurance claims if you provide us with complete insurance information. We cannot accept responsibility for collecting patient claims and settlement of disputed claims. The patient is ultimately responsible for payment of fees. In the event payment is not received by the agreed upon date determined by our office, your account will be turned over to our Collection Agency and you will be charged an additional 35% of the balance due for collection.

_____ I understand that any pretreatment cost quoted by an employee of Sampson Dental Group is an *estimate*. Whatever your insurance does not pay for, you are responsible for.

_____I understand that at Sampson Dental Group, patients come first. To avoid long wait times, SDG requires a prepayment to book any services rendered which are non refundable.

CANCELLATIONS AND BROKEN APPOINTMENTS

____At our office, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. **We, therefore, require at least 2 business days' notice prior to canceling or rescheduling appointments. Patients who cancel or reschedule their appointment without proper notice will be assessed a $10.00 fee for every 10 minutes of appointment time to offset the lost production time and estimated amount of time and effort the staff has already spent preparing for the appointment. This charge is not covered by insurance and will therefore be your responsibility. Please be aware of current office hours to avoid calling on a day the office is not open.**

____ I understand that if my insurance is provided by the state and I do not cancel or reschedule my appointment with at least 2 business days' notice, my file will be subjected to closure and my insurance company will be informed.

I certify that the information provided is accurate to the best of my knowledge. I also certify that I (or my dependent) have insurance coverage with_____and assign directly to Sampson Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all professional services rendered, whether or not paid by the insurance. I also acknowledge that if my account is sent to an attorney or collection agency, I am responsible for any and all of these fees charged to my account. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature **Date**

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose of this form is to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. ****__You may refuse to sign this acknowledgement.__**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Please Print Name Date

_____

(Patient signature or Parents if patient is a minor)

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:.

_____ _____

(Please Print Name) (Relationship)

_____ _____

(Please Print Name) (Relationship)

_____ _____

(Please Print Name) (Relationship)

TIME 8:46 AM DATE 1/9/2015

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

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 _____