

## PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_ (PLEASE PRINT) Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Middle Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
☐ Married ☐ Widowed ☐ Single ☐ Minor  
☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse/Parent Birthdate \_\_\_\_\_

Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse/Parent's Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check boxes that apply):

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Allergies	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc.	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? \_\_\_\_\_

\_\_\_\_\_

## CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

## MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of \_\_\_\_\_  
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

## INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

## FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Parent

## MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

## MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

JAMES SAMPSON DMD, PC  
763 SHADES MOUNTAIN PLAZA  
BIRMINGHAM, AL 35226

I, \_\_\_\_\_, consent to be a patient of James Sampson DMD and staff and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. We will always strive for perfection, but when dealing with the human body, no guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I understand that with any dental procedure there are potential risks, many of which are very rare, but nonetheless possible, including, but not limited to: teeth sensitivity, gum sensitivity and/or bleeding, sore jaw from remaining open for a procedure, allergic reaction to medications or dental materials, abrasions to soft tissue, aspiration or swallowing of dental materials or small instruments.
5. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover. I understand that my actual needs and my dental insurance coverage may not always align.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

\_\_\_\_\_  
Patient or Guardian Name

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY PRACTICES

### Protecting Your Confidential Health Information is Important to Us

#### 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.

#### Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

#### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

#### How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

#### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

#### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

#### In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

#### To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

## NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

#### As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

#### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

#### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

#### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

#### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

#### Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

#### Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

#### Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

#### Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

#### To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.



# Protecting Your Confidential Health Information is Important to Us

## To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

### For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

### In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

### Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

## PATIENT RIGHTS

You have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

## Patient Acknowledgment

Patient Name(s): \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

### Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

### Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

### Amend Your Health Information

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

### Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Officer will first contact you to determine whether you wish to modify or withdraw your request.

### Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

### Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

### Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

### Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

## Adult Fluoride Varnish Treatment



The ADA now recommends fluoride varnish application for adults and not just children. The latest studies confirm that fluoride treatment on adults has many benefits including:

- Remineralizes and strengthens areas of weakened enamel
- Slows the loss of minerals from teeth, slowing the process of a cavity and acid erosion
- Decreases bacterial colonization on the teeth
- Decreases teeth sensitivity

This is elective, but based on the newest recommendations, we ask that all of our patients consider fluoride treatment, but especially if one has a history of dental issues, older dental restorations, gum recession, consumption of acidic foods/beverages, or dry mouth issues.

### How Much Does It Cost?

Insurance companies **will not** cover the cost of fluoride treatment on adults. Most dental offices provide this treatment for a cost of \$30-\$40 due to suggested mark-ups. Although the varnish itself is expensive, it is very simple to apply, so we do not believe there is a need to increase the cost. We offer it for only **\$10**.

### What to Expect?

- Following your cleaning and exam, a small brush is used to apply the varnish to the cheek sides of your back teeth. **This takes about 20 seconds and is pain free.**
- The varnish sticks to the teeth and is slowly released over the next couple hours with your own saliva to reach all areas of your teeth (not just where it was placed).
- For a short while, you will notice the teeth will feel slightly sticky where it was placed.
- There are no restrictions. You can eat/drink immediately.
- Just wait to brush your teeth for a few hours.

*Please make a selection below and hand this sheet to our staff to keep for future reference.*

- ☐ **YES.** Please apply the fluoride varnish treatment following my cleanings
- ☐ **No.** I would like to opt-out of these treatments
- ☐ **Not sure.** Please talk to me more about it