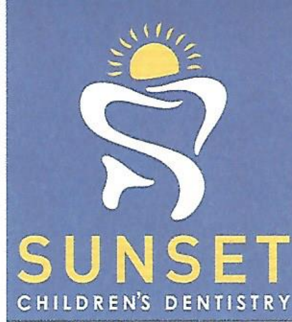
KATHI SAMPLE, DMD
General Dentist



JEFFREY JACKSON, DDS
Pediatric Dentist

Office Policies

We are open to serve you, answer any questions, or schedule an appointment during the following hours:

Monday-Thursday 8:00 a.m.- 5:00 p.m.

Appointments

The office attempts to schedule appointments at your convenience and when time is available. Please note that it is our policy to schedule preschool children in the morning. We have found that children are more alert and less stressed in the morning helping to ensure a more positive experience.

Since appointment times are reserved exclusively for each patient, we kindly ask for a 24 hour notice if you need to cancel or reschedule your child's appointment. This way we can give the allotted time to another patient in need of an appointment. We are aware of unforeseen events, but we ask you for your cooperation in this matter. *Continued broken appointments (3) may be cause for dismissal from practice*. A broken appointment is considered "no show" or cancellation of an appointment the same day.

When calling to make **New Patient appointments** please make sure to have all information including, patients name, date of birth, insurance: (subscriber name, Id#, SSN#, date of birth, employer, insurance company name, group#, insurance phone number). This information is needed to verify and schedule appointments.

Permission for Photographing Your Child

Sunset Children's Dentistry would like to take a photo of your child to attach to their account for charting purposes since we are chartless. This will allow our staff to identify your child. From time to time, we may also take photos of your child's teeth in effort to better describe procedures that are recommended. Procedures may also be photographed. We would like your permission to use these photos as you agree to one of the following: Please check one

____Yes, I grant you permission to take and use photos of my child/children for individual account reference, procedure information, case studies, web-site information, newsletters, social media and/or bulletin boards.

____Yes, I grant you permission to use my child/children's picture for purpose of identity with charting and account reference only.

____No, please do not take or use photos of my child/children.

Emergencies

We are always available to address your child's dental emergency. Please contact the office after hours to receive the emergency contact information and how to reach Dr. Kathi Sample & Associates.

Insurance

We file dental insurance as a courtesy to you. Please understand that we do not have a contract with your insurance company, only you do. We cannot guarantee, and are not responsible for how your insurance company handles its claims or how they pay. We try our best to only estimate your portion of the cost of treatment. We are participating providers with **Met Life, Cigna, United Concordia-(Military Only)** and **Delta Dental**. For more information or for assistance with any insurance related question, please contact our office during regular business hours. Your copay is due at the time services are rendered. By law your insurance company is required to pay each claim within thirty (30) days of receipt. Any outstanding patient balances left on your account for over 30 days will be your responsibility, whether your insurance has paid or not. All outstanding balances over 90 days will be sent to collections and you will be responsible for any fees incurred from the collection agency. ***If there is no insurance, your payment is due at time of services.*** **We accept cash, check, Visa, MasterCard, Discover and American express. There is a $35.00 fee for ALL returned checks.**

****We DO NOT allow Insurance Companies to dictate our treatment recommendations. The treatment that our doctors recommend is based on the individual needs of your child as per the guidelines set forth by the American Academy of Pediatric Dentistry (AAPD).**

Signature____**Date**___________________________

5080 SUNSET BOULEVARD | SUITE B | LEXINGTON, SC 29072 | 803.996.0753 | FAX: 803.996.0418

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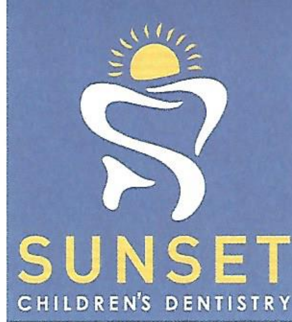

JEFFREY JACKSON, DDS
Pediatric Dentist

Welcome to our practice! In order to know you and your child better, please complete the information requested as completely as possible.
If you have any questions, please ask for assistance. Thank You!

Patient Information
Child's Name:____
Last First MI Nickname
Male____ **Female**____ **Date of Birth:**______________**Child's SSN#:** ____________________
Hobbies/ Pets:____
Names and ages of any other children in the family:_________________________
____
Do parents live together?____ **Yes**____ **No** **If not, with whom does the child live?** ________________

Parent/Guardian Information
Mother____Stepmother____Guardian____
First Name ____________________ Middle Initial_________Last Name ______________________

Address _________________________________City, State, Zip______________________________

Home Phone ____________________Cell___________________Work ______________________

Birth Date _______________ SSN#______________________Marital Status_________________

Occupation ____________________________ Email ______________________________________
Does this person have the legal right to make health care decisions for the patient listed above? ____**Yes**____**No** **Relationship to child** __________________________

Parent/Guardian Information
Father____Stepfather____Guardian____
First Name ____________________ Middle Initial_________Last Name __________________

Address _________________________________City, State, Zip _________________________

Home Phone ____________________Cell___________________Work___________________

Birth Date _______________ SSN#______________________Marital Status_____________

Occupation ____________________________ Email _________________________________
Does this person have the legal right to make health care decisions for the patient listed above? ____**Yes**____**No** **Relationship to child** ______________________________

List any person(s) you do not want patient/family information released to:_____________
____

List any person(s) allowed to bring patient to an appointment and make dental/financial decisions for the above patient:____

How were you referred to our practice:_______________________________________
Who is your family dentist?____

PRIMARY INSURANCE INFORMATION

Name of Insured ______________________________Relationship to child _________________
Insured SSN# ________________________________ Insured Birth Date __________________

Employer _______________________________ * Ins. Company ___________________________
ID# ____________________________ Policy/Group # ___________________________________
Insurance Phone Number ______________________________

SECONDARY INSURANCE INFORMATION

Name of Insured ______________________________Relationship to child _________________
Insured SSN# ________________________________ Insured Birth Date __________________

Employer _______________________________ * Ins. Company ___________________________
ID# ____________________________ Policy/Group # ___________________________________
Insurance Phone Number ______________________________

FINANCIAL POLICY

Your child's treatment cost is due and payable on the day of service. Understand that dental insurance may cover only part of your child's dental treatment, based on your specific dental benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of coverage need to be handled through the insurance company directly by you. By signing below, I agree that I am responsible for any fees incurred on this account for collection actions necessary and/or delayed payment by the responsible party and/or insurance company.

Signature of
Parent/Guardian_____________________________________Date_______________________

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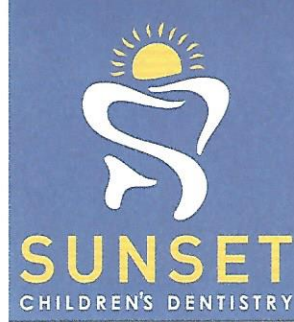

JEFFREY JACKSON, DDS
Pediatric Dentist

Patients Name:_______________________________________**DOB:**_________________________

Medical History

Child's pediatrician:____________________________________Phone Number:_________________
Date of last visit:_______________________________________
Has your child been hospitalized or had surgery since birth? ____Yes ____No If Yes, please explain:
____
____
Does your child have any handicaps or disabilities? ____Yes____No Please list: ______________
____

ADD/ADHD	YES	NO	Hepatitis	YES	NO
AIDS/HIV	YES	NO	Kidney/Stomach Disorder	YES	NO
Anemia/ Sickle Cell	YES	NO	Learning Disabilities	YES	NO
Asthma	YES	NO	Liver Problems	YES	NO
Autism/Asperger's	YES	NO	Lung Disease	YES	NO
Abnormal Bleeding	YES	NO	Measles/Mumps	YES	NO
Bladder Issues	YES	NO	Mental/Emotional Disorder	YES	NO
Cancer/ Tumors	YES	NO	Nose/ Throat Disorder	YES	NO
Cerebral Palsy	YES	NO	Rheumatic Fever	YES	NO
Chicken Pox	YES	NO	RSV	YES	NO
Diabetes	YES	NO	Scarlet Fever	YES	NO
Epilepsy/Convulsions	YES	NO	Seasonal Allergies	YES	NO
Ear Problems	YES	NO	Sinus Problems	YES	NO
Tubes in Ears	YES	NO	Skin Disorder	YES	NO
Hemophilia	YES	NO	Speech Problems	YES	NO
Heart Condition/ Murmur	YES	NO	Thyroid Disease	YES	NO
Premed Needed	YES	NO	Tuberculosis	YES	NO

If any yes answers above please explain or give additional details:_________________________
____
____
Please list all current medications-prescription, non-prescription and supplements:_____________
____
____

Allergies

____**None** ____**Penicillin/Amoxicillin** ____**Sulfa** ____**Latex** ____**Aspirin** ____**Anesthetic**

____**Other (Please List):**____

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DENTAL HISTORY

Is this your child's first visit to the dentist? ____ YES____NO If no, please give date of last dental visit:________________________ Previous Dentist:_____________________________________
Do you have a copy of your child's dental records: ____ YES____ NO?
Is your child on a bottle?____YES ____ NO If not, at what age was it discontinued?____________
Is your child a thumb/finger sucker or ever used a:____pacifier____YES____NO
Age discontinued_____
Is your primary source of water from a well?____YES____NO
Does your child take fluoride in any form?____Toothpaste____Rinse____ Tablet____City Water/Nursery Water
Has your child had any problems with previous dental treatment?____YES____NO If yes, please explain:

____

____

Does your child have any dental conditions you are concerned about today? ____YES____NO If Yes, please
explain:____

____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent/Guardian or personal representative of this patient and have the legal right to authorize medical and dental care for this child. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Sunset Children's Dentistry of any changes in my child's medical or dental status. I authorize the dentists and staff of Sunset Children's Dentistry to release any information including any treatment rendered or diagnosis of any treatment for my child to any third party payers and/or health practitioners.

Signature of
Parent/Guardian:____Date____________________

Printed Name of
Person signing:____Date____________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Parent/Guardian Giving Consent

Name: ____

Address: ____

Telephone #: ______________________Email:____________________

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 our 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. We encourage you to read it carefully and completely 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 maintain.

By signing this authorization, I understand I am giving authorization to the person(s) listed below to bring my child to his/her dental appointments and give permission to Sunset Children's Dentistry to provide them with the information regarding my child's dental appointments and billing. I authorize the person(s) to make treatment decisions on my behalf. I recognize there will be times when my presence and/or signature will be required for certain procedures. **I understand if my child is present with someone not listed below he/she will NOT be seen. I understand I must request in writing for a person to be removed from the list.**

1.
2.
3.
4.
5.

Right to Revoke: You will have the right to revoke this Consent at any time by giving Sunset Children's Dentistry written notice of your revocation. 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 health care 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:__________________

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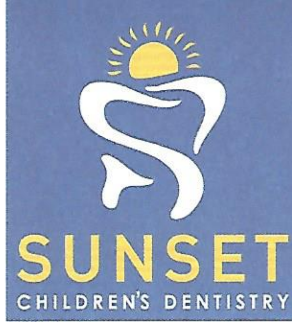

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Dental Records Release Form

Patient Name:____

Date of Birth: ___________________________

Phone Number:___________________________

Other Family Members to Transfer: ____

____

____

Previous Dentist or Practice Name: ______________________________________

Address: ____

City, State, Zip: ____

Phone Number: _____________________________________

Please forward any of the following information that you have: x-rays, charting to **Sunset Children's Dentistry.**

I hereby give you permission to release any and all of my dental records to **Sunset Children's Dentistry.**

____ ___________________________

Patient/Guardian Signature **Date**

If records are digital, please email to:

contact@sunsetchildrens.com

Or mail to: **Sunset Children's Dentistry**
5080 Sunset Blvd Suite B
Lexington, SC 29072