

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

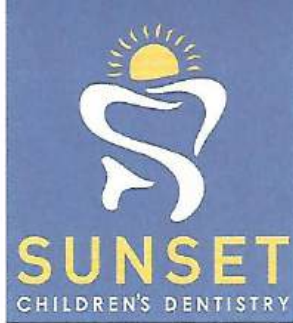
We are always available to address your child's dental emergency. Please contact the office after hours to receive the emergency contact information and how to reach Dr. Kathi Sample & Associates.

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 _____



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 _____

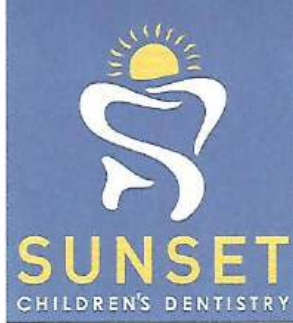
ID# _____ Policy/Group # _____

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 _____ Date _____
Parent/Guardian



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): _____

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: _____

KATHI SAMPLE, DMD
General Dentist



JEFFREY JACKSON, DDS
Pediatric Dentist

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