Center for Advanced Dentistry
BRAD SAMMONS, DDS

PATIENT REGISTRATION

Todays Date:_____

Patient's Name:_____ Sex: M / F Birthdate:_____

Home Address_____ City:_____ State:_____ Zip:_____

Home Phone #: _____ Cell Phone # _____ Social Security #_____

Email:_____ Marital Status: Single, Married, Child, Other

Employer:_____ Work # _____ Full time student? Yes No

EMERGENCY CONTACT: Name _____ Number _____

Name of spouse (Parent if minor) _____ Spouse's employer: _____

Spouse's Soc. Sec. #_____ Spouse's Birthdate:_____ Work phone #_____

How did you hear about our office?_____ Reason for visit:_____

Is there anything we can to do to make this appointment a better experience for you? _____

_____

(Primary Carrier) Subscriber name:_____ DOB:_____ SS / ID #: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

(Secondary Carrier) Subscriber name:_____ DOB:_____ SS / ID#: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

Medical plan Subscriber name:_____ DOB:_____ SS / ID#: _____

Employer name:_____ Insurance Co:_____ Phone #: _____

Insurance Co Address:_____ Group #_____ Relationship:_____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Payment is due at the time service is provided. Our office accepts Cash, Check, MasterCard, Visa, and Care Credit.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred

Cancellation Policy: To provide our patients with the best care, we require a 24hr notice to cancel / reschedule your appointment. A fee of $25 will charged for all failed or short notice canceled appointments.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature: _____ Date:_____

DENTAL HISTORY

Please check any of the following problems that apply to you.				**If you could whiten your teeth for a cost anyone could afford, would you do it?**	☐	
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐			**Do you smoke or use chewing tobacco?** How much? For how long?	☐	
-Headaches, earaches, neck pain	☐			**If I could change my smile, I would:**	☐	
-Jaw joint pain	☐			-Make them whiter	☐	
-Teeth or fillings breaking	☐			-Make them straighter	☐	
-Grinding or clenching teeth	☐			-Close spaces	☐	
-Bleeding, swollen or irritated gums	☐			-Replace black metal fillings with tooth colored restorations	☐	
-Loose, tipped or shifting teeth	☐					
-Bad breath	☐			-Repair chipped teeth	☐	
Do you have or have you had any of the following?				-Replace missing teeth	☐	
				-Replace old crowns that don't match	☐	
-Dentures	☐			-Have a smile makeover	☐	
-Partial dentures	☐			**On a scale of 1 – 10, with 10 being the highest rating:**		
-Braces	☐					
-Periodontal (gum) treatments	☐			-How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10		
Please share the following dates:				-Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10		
-Your last cleaning	___ / ___			-Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10		
-Your last oral cancer screening	___ / ___					
-Your last complete X-Rays	___ / ___					
Name of Previous Dentist _____						
City _____ **State** _____ **Phone Number** _____				**Why did you leave your previous dentist?** _____		
Have you ever considered Botox or Fillers? _____				**What is the most important thing to you about your dental visit today?** _____		

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Snoring
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ Other
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	☐ CPAP
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	☐ Sleep Apnea

Do you have any of the following drug allergies?		**Are you under a physician's care? What for?**
☐ Aspirin	☐ Codeine	_____
☐ Darvon	☐ Erythromycin	**Are you taking any medications? What?**
☐ Nitrous Oxide	☐ Latex	_____
☐ Percodan	☐ Penicillin	**Family Physician** **Phone Number**
☐ Local Anesthetic	☐ Sulfa	_____ _____
☐ Tetracycline	☐ Other	

Patient Signature (guardian) _____ Date_____

Center for Advanced Dentistry
BRAD SAMMONS, DDS

Dental release form

HIPAA Release form

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

[ ] I authorize the release of my X-rays and chart to any referrals given to me by this office.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] Please leave a message asking me to return your call

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

OFFICE POLICY OF BRAD SAMMONS, D.D.S.
COSMETIC AND FAMILY DENTISTRY

Thank you for choosing our office! We will work hard to maintain or give you that nice healthy smile you want! In order to achieve this goal, we ask that all patients read, sign and follow the office policies listed below.

~ Please be prompt for your appointment time. We strive to run on time. If you arrive late for your appointment, it affects every patient after you that day. We reserve the right to charge for failed appointments, or those that are cancelled with less than 24 hours notice.

~ Office hours are as follows: Monday 8:00-5:00, Tuesday 9:00-5:00, Wednesday 9:00-5:00, Thursday 8:00-4:00. Early morning and after school hours are available to accommodate your busy schedule, but as you can expect, are frequently requested. Please call well in advance for these times. If an early or late appointment is not kept, please do not expect to be given another.

~ Please be aware of the specifics of your insurance policy. We will try to verify benefits, but this is very time consuming. Be prepared to provide us with insurance company phone numbers and mailing addresses. We will submit your claim for you, and ask that you pay your co-payment and/or deductible at the time of service.

~ Payment is due at the time of service. We accept cash, checks, Visa, and MasterCard. Other financing options are available; please check with the front desk.

~Emergencies will be handled promptly. Please call early to be seen the same day. Dr. Sammons does not phone in medication without seeing the patient first. If a dental emergency arises, outside of regular business hours, Dr. Sammons may be reached at 506-0754.

~ Occasionally, it is necessary to dismiss a patient from the practice. This action would result from failed appointments, rude behavior toward staff members or other patients or failure to keep account balances paid and current.

PATIENT SIGNATURE: _____ DATE:_____