Mountain View Dentistry
Justin Sama DDS

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Marital Status: _____ Gender: *M* *F*

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Mailing Address: _____
Street / P.O. BOX City State Zip Code

Email Address: _____

Health Information

Do you <u>currently have</u> or have a <u>history of</u> any of the following? Please check all that apply:

- ☐ Food Allergies: _____
- ☐ Latex Allergy
- ☐ Other Allergies: _____
- ☐ Anemia
- ☐ Arthritis Osteo/Rheumatoid
- ☐ Artificial Joint:_____
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Clotting Issues/Excessive Bleeding
- ☐ Cancer:Type _____
- ☐ Radiation or Chemo
- ☐ Circulatory Problems
- ☐ Diabetes Type 1 or 2
- ☐ Epilepsy
- ☐ Dizziness / Fainting
- ☐ Anorexia or Bulimia
- ☐ Stroke
- ☐ Glaucoma / Cataracts
- ☐ Hyper or Hypo Thyroid
- ☐ Heart Problems: Type:_____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker or Defibrillator
- ☐ Artificial Heart Valve
- ☐ Heart Attack
- ☐ Sexually Transmitted Disease Type: _____
- ☐ HIV / AIDS
- ☐ Hepatitis Type: _____
- ☐ Drug / Alcohol Dependency
- ☐ Kidney or Liver Disease
- ☐ High Cholesterol
- ☐ Anxiety or Panic Attacks
- ☐ ADHD or ADD
- ☐ Acid Reflux
- ☐ Osteoporosis / Osteopenia
- ☐ Respiratory Problems
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever/Jaundice
- ☐ Migraines/Frequent Headaches
- ☐ Sinus Problems
- ☐ Celiac or Crohn's Disease
- ☐ Tuberculosis
- ☐ Tumors / Growths
- ☐ Head Injuries
- ☐ Surgeries:
  _____
  _____
  _____

Do you have any health problems not listed above? ☐ Yes ☐ No If yes, please explain:_____

- Are you currently taking any medications? ☐ Yes ☐ No If yes, Please list Prescription/OTC/Herbal:_____

_____

- Are you allergic to any medications ☐ Yes ☐ No
  If yes, please list: _____
- Name of Physician: _____ Date of last Medical Visit:_____
- Have you ever had any complications following a medical or dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past three years? ☐ Yes ☐ No
  If yes, please explain: _____
- **(Women)** Are you pregnant or do you suspect you may be pregnant or nursing? ☐ Yes ☐ No Specify:_____
  Due Date:_____
- Have you ever been told you needed to Pre-medicate with an antibiotic prior to your dental appointments? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you EVER taken any Bisphosphonate medications oral or injections? (Example:Fosamax/Actonel/Boniva/Zometa/Aredia)
  ☐ Yes ☐ No If yes please explain:_____
- Do you use any of the following? Alcohol: Yes / No, Recreational Drugs: Yes / No Tobacco: Yes / No
  Type of Tobacco? _____ How much Tobacco? _____ Interested in Quitting: Yes / No

To the best of my knowledge, all of the preceding information provided are correct. Any changes in my/my child's health it is my responsibility to inform the practice at the next appointment.

Signature of patient, parent or guardian _____ Date:_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Appointment Policy

Our goal is to provide quality dental care in a timely manner. In order to do so we ask that our patients adhere to our appointment cancellation and no show policy. The policy enables us to better utilize available dental appointments for our patients in need of dental care.

Our Commitment to You:

- We will work with you to find an appointment time that best fits your schedule.
- We will make every effort to remind you of your appointment at least two days prior either by phone call, text message or email. You can let us know the best way to reach you for these confirmations.
- If we are running behind schedule we will do our best to let you know in advance.

Your Commitment to Us:

- Appointments must be confirmed within 24 hours of appointment time.
- If you miss our confirmation call/text/email, please contact us as soon as possible to confirm. If the office is closed please leave us a voicemail. All Monday appointments must be confirmed by 9:00am on Thursday's. Appointments that are not confirmed may result in cancellation.
- Please arrive for your appointment on time. You may be asked to come early to update paperwork and that allows us to be able to see you at your appointment time.

Cancellation of an appointment: In order to be respectful of other patients' needs we ask that you contact our office 24 hours prior to your appointment. Appointments that are not confirmed may result in cancellation**.**

Late Arrival: If you arrive 10 minutes past your appointment time we may have to reschedule your appointment. If we are able to complete a portion of your appointment you may be asked to come back another time to complete what else is needed.

No Show: A "No Show" is an appointment that was not canceled in advance (a minimum 24 hour in advance) and you did not arrive at office. No Show appointments will not be rescheduled.

Multiple short notice cancellations may result in us recommending you to find another dental provider to continue your dental care. If canceling an appointment is unavoidable, we respectfully ask that you give us as much advance notice as possible.

Acknowledgement: My signature below indicates that I have read, understand and agree to the appointment policy above.

Patient Signature:_____ Date:_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. The unpaid balance over 60days, unless previously written financial arrangements are made, can result in further action. I understand that the fee estimate listed for this dental care can only be extended 90 days from the date estimate is given. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me at my listed phone numbers to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____

Signature of patient, parent or guardian

Authorization for Release of Information
For Mountain View Dentistry
Justin Sama DDS

Name of Patient _____Date of Birth _____

Justin Sama DDS is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

☐ Voice Mail	☐ Time and date of appointment
☐ Text Messages	☐ Any communication
☐ E-mail	☐ Financial Information
☐ Spouse/Other (provide name & phone number) _____	☐ Financial
☐ Parent (provide name & phone number) _____	☐ Dental treatment
	☐ Appointments _____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature:_____ Date:_____

Acknowledgement of Receipt of Privacy Practices

I have read a copy if the Notice of Privacy Practices for Mountain View Dentistry. A copy can be given or emailed to me at my request.

Signature:_____ **Date**:_____

For Office Use Only

Unable to attain signature from patient due specific explanation list:_____
