



SAMANTHA D. KING, D.M.D.

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. Name I prefer to be called M F
Single Married Birthdate Social Security Number
Home Address City State Zip
Home Phone Cell Phone E-Mail
Employer Business Phone
Business Address City State Zip
Whom may we thank for referring you to our office?
How do you prefer to be contacted? Home Phone Cell Phone Business Phone E-Mail
Are you interested in text notification for appointments? Yes No

DENTAL INSURANCE INFORMATION

Name of Insured Person Relationship to Patient
Employer Birthdate of Insured
Insurance Co. Name Subscriber ID Group #
Insurance Co. Address City State Zip

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured Person Relationship to Patient
Employer Birthdate of Insured
Insurance Co. Name Subscriber ID Group #
Insurance Co. Address City State Zip

RESPONSIBLE PARTY

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Name of Person Responsible for Payment Relationship to Patient
Is the person responsible for payment currently a patient in our office? Yes No
Home Address City State Zip
Home Phone Cell Phone E-Mail
Employer Business Phone
Business Address City State Zip



SAMANTHA D. KING, D.M.D.

HEALTH HISTORY

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Have you ever been advised to take prophylactic antibiotics before dental treatment? ...  Yes  No
If yes, please list reason(s) \_\_\_\_\_

Have you ever been advised not to take a particular medication? ...  Yes  No
If yes, please list \_\_\_\_\_

Do you take blood thinners? ...  Yes  No

Have you ever taken bone loss prevention drugs (bisphosphonates) for osteoporosis, metastatic cancer, or other conditions?
Examples of bisphosphonates are alendronate (Fosamax), risedronate (Actonel), pamidronate (Aredia),
ibandronate (Boniva), and zoledronate (Zometa, Reclast) ...  Yes  No

Are you allergic to any of the following?

- Yes No
  Latex
  Penicillin or any other antibiotic: If yes, please list \_\_\_\_\_
  Other allergies: If yes, please list \_\_\_\_\_

Do you have, or have you ever had, any of the following?

- Yes No Yes No
  Alcohol or Drug Addiction
  Anaphylaxis
  Artificial Joint Replacement (hip, knee, etc.)
  Artificial Heart Valve
  Asthma
  Bleeding Problems or Bleeding Disorder
  Cancer
  Chemotherapy
  Cold Sores
  Congenital Heart Failure
  Corticosteroid Treatment
  Dental Phobia or Anxiety
  Diabetes
  Endocarditis
  Epilepsy or Seizures
  Fainting Spells or Dizziness
  Heart Pacemaker
  Heart Attack or Heart Problems
  Hepatitis
  History of Tobacco Use or Vaping
  High Blood Pressure
  HIV or AIDS
  HPV (Human Papilloma Virus)
  Kidney Problems
  Liver Problems
  Lung Problems
  Major Operations
  Memory Problems
  Osteoporosis / Osteopenia
  Psychiatric Care
  Respiratory Problems
  Radiation Treatment
  Rheumatic Fever
  Sinus Problems
  Stomach or Intestinal Problems
  Stroke
  Thyroid Problems
  Tuberculosis
  Tumors or Growths
  If Female, Are you Pregnant?
  Other Health Problems

Please provide additional information for all "Yes" responses:
\_\_\_\_\_
\_\_\_\_\_

Do you take any medications? ...  Yes  No

If Yes, please list medications and the reason why you are taking them:
Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Medication: \_\_\_\_\_ Reason: \_\_\_\_\_
Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Medication: \_\_\_\_\_ Reason: \_\_\_\_\_
Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Medication: \_\_\_\_\_ Reason: \_\_\_\_\_
Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



SAMANTHA D. KING, D.M.D.

## DENTAL HISTORY

Patient Name \_\_\_\_\_

What is the reason for your dental visit today? \_\_\_\_\_

Do you currently have any teeth that are sensitive?

Yes  No If Yes, please explain \_\_\_\_\_

Do you have a history of trauma to any teeth?

Yes  No If Yes, please explain \_\_\_\_\_

When was the last time you saw a dentist? \_\_\_\_\_

When was your last professional cleaning? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Have you ever been treated for periodontal disease (gum disease)? .....  Yes  No

Do you feel that you can chew well with your teeth? .....  Yes  No

Do you grind or clench your teeth? .....  Yes  No

Do you ever have jaw pain or jaw muscle soreness? .....  Yes  No

Have you ever worn a night-guard or been told that you should? .....  Yes  No

Do you have any teeth or restorations that you are unhappy with? .....  Yes  No

Would you like to discuss esthetic improvements that can be made to your smile? .....  Yes  No

**HIPAA**  
**Notice of Privacy Practices**  
**Effective: April 14, 2003**  
**Revised: February 16, 2026**  
**Welsh and King Dental**  
**320 Union Street**  
**Portsmouth, NH 03801**  
**Phone: 603-436-2144**  
**Fax: 603-436-0020**  
**office@welshandking.com**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully. By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at [www.welshandking.com](http://www.welshandking.com) or calling the Privacy Officer at 603-436-2144.

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

**Treatment:** We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

**Healthcare Operations:** We may use or disclose, as needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

**Appointment Reminders and Health-related Benefits and Services:** We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

**Friends and Family Involved in Your Care:** If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

**Business Associate:** We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

**Proof of Immunization:** We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

**Incidental Disclosures:** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of your health information.

**Emergencies or Public Need:**

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Research:** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

## **SUD RECORDS DISCLOSURE AND PROTECTIONS**

The confidentiality of your substance use disorder (SUD) treatment records maintained by this facility is protected by federal law and regulations (42 CFR Part 2 and the HIPAA Privacy Rule). Generally, we cannot disclose information that identifies you as a person with a substance use disorder to anyone outside the facility without your written consent. With your written consent, we may use and disclose your SUD information for treatment, payment, and health care operations. You may revoke your consent at any time in writing, except to the extent that we have already relied on it.

**Use and Disclosure for Legal Proceedings:** SUD treatment records from programs subject to 42 CFR Part 2 generally cannot be used or disclosed in legal proceedings against the patient unless there is specific written consent or a court order.

**Redisclosure of SUD Records:** If SUD records are disclosed with patient consent, the recipient can re-disclose them to contractors or legal representatives for specified TPO activities if a written agreement is in place that maintains confidentiality. Otherwise, redisclosure is prohibited.

**SUD Counseling Notes:** SUD counseling notes require a separate, specific consent for their use or disclosure and cannot be used or disclosed based on a general TPO consent.

**Fundraising Communications:** If SUD records are used or disclosed for fundraising, patients must be given a clear opportunity to opt out.

**Exceptions:** We may share information without your consent in a medical emergency, to report suspected child abuse as required by law, or to law enforcement if you commit a crime on our premises.

**Stricter State Laws:** If state law offers greater protection, the more stringent state law applies.

## **REQUIREMENT FOR WRITTEN AUTHORIZATION**

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

**Most Uses of Psychotherapy Notes,** when appropriate.

**Marketing:** We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

**Sale of Protected Health Information:** We will not sell your Protected Health Information to third parties.

**You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.**

## **PATIENT RIGHTS**

**Right to Inspect and Copy Records.** You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**Right to Amend Records.** If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

**Right to an Accounting of Disclosures.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Right to Receive Notification of a Breach.** You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

**Right to Request Restrictions.** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

**Right to Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

**Right to Have Someone Act on Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

**Right to Obtain a Copy of Notices.** If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

**Right to File a Complaint.** If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 603-436-2144 or with the U.S. Department of Health and Human Services, Office of Civil Rights. You may email the OCR at [OCRMail@hhs.gov](mailto:OCRMail@hhs.gov) or call the U.S. Department of Health and Human Services, Office for Civil Rights toll-free at: 1-800-368-1019, TDD: 1-800-537-7697. We will not withhold treatment or take action against you for filing a complaint.

**Use and Disclosures Where Special Protections May Apply.** Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.



**Samantha King, DMD**  
320 Union Street  
Portsmouth, NH 03801  
P (603) 436-2144 F (603) 436-0020  
office@welshandking.com

**ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Welsh and King Dental's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



## **Samantha King, DMD**

320 Union Street  
Portsmouth, NH 03801  
(603) 436-2144

### **Missed Appointment Policy**

The loss of an appointment is a loss for everyone. When an appointment is not kept and no notice is given, the appointment that was left open could have been given to another patient. We understand that unforeseen circumstances arise, and for that reason, we will not charge a fee for the first missed appointment. We ask that you let us know 24 business hours (or more) in advance if you are unable to keep your appointment. Missed appointments, or appointments cancelled or re-scheduled with less than 24 business hours, will be charged \$75. This fee cannot be billed to your insurance company and will be your responsibility. No future appointments can be scheduled without payment of this fee.

We appreciate your understanding and consideration.

I have read the above and by signing below I acknowledge this cancellation policy.

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Print Patient Name

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Signature

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Date



**Samantha King, DMD**

**PERMISSION TO RELEASE DENTAL RECORDS**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of dental practice/dentist to obtain dental records from: \_\_\_\_\_

**Please email my x-rays to: [office@welshandking.com](mailto:office@welshandking.com)**

Dr. Samantha King  
320 Union St.  
Portsmouth, NH 03801  
Phone: 603-436-2144

***Please send the x-rays as individual x-rays (not one picture with all the x-rays on it) & send in Dexis format, if possible.***

Thank you!

Signature: \_\_\_\_\_ Date: \_\_\_\_\_