Today's DATE______/______/__________

We are pleased to welcome you to our practice! Please take a few minutes to fill out these forms as completely as you can. If you have any questions we would be happy to help.

Patient's Full Name: ________________________________ **Birth Date:** ________/__________/__________ _

Sex: __________ **Marital Status:**______________________ **Patient SSN:** ____________-_____-__________

Home Phone: (_______)_________-______________________ **Cell Phone:** (_______)_________-______________

Occupation : ______________________________ **Work phone:** (_______)_________-______________

Employer: ______________________________ **Phone:** (_______)_________-______________

Email: ____

Mailing Address: ______________________________**Unit #**_____ **City:** ____________________**Zip:**__________

Physical Address if different: ______________________**Unit #**_____ **City:** ____________________**Zip:**__________

How did you hear about us? ____

Who is responsible for the account? ______________________**Phone:** (_______)_________-________________

Emergency Contact: ______________________________**Phone:** (_______)_________-________________

Reason for today's visit? ______________________________ **How long since Last Exam?**__________________

Dental Insurance Information

Primary Insurance Carrier:____

Subscriber name: ______________________________ **Relationship:**____________________

SSN: _________-________-__________ **DOB:**________________ **Phone:** (_______)_________-________________

Employer: ______________________________ **Work Phone:** (_______)_________-________________

Secondary Insurance Carrier: ____

Subscriber name: ______________________________ **Relationship:**____________________

SSN: _________-________-__________ **DOB:**________________ **Phone:** (_______)_________-________________

Employer: ______________________________ **Work Phone:** (_______)_________-________________

3rd Insurance Carrier: ____

Subscriber name: ______________________________ **Relationship:**____________________

SSN: _________-________-__________ **DOB:**________________ **Phone:** (_______)_________-________________

Employer: ______________________________ **Work Phone:** (_______)_________-________________

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my insurance eligibility or employment status, I will inform the staff at the next appointment. I am aware these forms must be updated and signed every rolling year. I have read the office Insurance/financial policy and agree to the conditions as stated above.

X______________________________________ **Date:** ______________________________

PATIENT OR GUARDIAN SIGNATURE

Medical Information

Patient's Name:____ Date: ___________________________________

Pharmacy: ____ Phone: (________)_________-_______________

Physician 's Name:____ Phone: (________)_________-_______________

Please list current medications below or circle [None]

1. ____________________________ 6.___________________________
2. ____________________________ 7.___________________________
3. ____________________________ 8.___________________________
4. ____________________________ 9.___________________________
5. ____________________________ 10.___________________________

Please list allergies below

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Do any of the following questions apply to your medical history? Please circle Yes or No

#	Question		
1.	Are you in good health?	Yes	No
2.	Currently Smoke/ use tobacco products	Yes	No
3.	Asthma / Lung Disease?	Yes	No
4.	COPD / Emphysema?	Yes	No
5	High Blood Pressure?	Yes	No
6.	Stroke?	Yes	No
7.	Heart Attack / Heart Disease?	Yes	No
8.	Artificial Heart Valve / Transplant? ..	Yes	No
9	Chest Pain (Angina)?	Yes	No
10.	Pacemaker – When? _ _ _ _	Yes	No
11.	Previous Infective Endocarditic?	Yes	No
12.	Kidney Disease / Dialysis?	Yes	No
13.	Thyroid / Adrenal Disease?	Yes	No
14.	Coumadin (Warfarin), Plavix, Aspirin?	Yes	No
15	Diabetes? A/B	Yes	No
16.	Hepatitis A, B, or C ?	Yes	No
17.	HIV?	Yes	No
18.	Herpes?	Yes	No
19.	Stomach Ulcers / GI Disease?	Yes	No
20.	Steroid Therapy?	Yes	No
21.	Seizures?	Yes	No
22.	Chemotherapy / Radiation / Cancer?	Yes	No
23.	Taken Bisphosphonates Drugs?	Yes	No
24.	Dry Mouth?	Yes	No
25.	Fainting Spells?	Yes	No
26.	Bleed or Bruise Easily?	Yes	No
27.	Pregnant or Possibly Pregnant?	Yes	No
28.	Do you take Birth Control?	Yes	No
29.	TMD / Pain in Jaw Joints?	Yes	No
30.	Do you grind or clench your teeth?	Yes	No
31.	Do you wear a night guard?	Yes	No
32.	Do you snore when sleeping?	Yes	No
33.	Psychiatric Care?	Yes	No
34.	Intake of Alcohol? Drinks Per day? _ _	Yes	No
35.	Drug Rehab/Pain management ?	Yes	No
36.	Cocaine in last 24 hours?	Yes	No
37.	Do you have any facial piercings?	Yes	No
38.	Sinus Problems?	Yes	No
38.	Excessive Thirst / Urination?	Yes	No
40.	Prosthetic joint of any kind?	Yes	No

Other: ____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist at the next appointment. I am aware this form must be updated and signed every rolling year.

X____ Date: ____

PATIENT OR GUARDIAN SIGNATURE

Anchorage Midtown Dental Center Insurance/ Financial Policy

Dear Valued Patient,

Thank you for selecting us as your dental health care provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Health Information and Insurance form before being seen.

As a courtesy, we can bill your insurance for services rendered. We will do our best to provide accurate information about your insurance policy and benefits remaining, however this information may not be accurate and it is your responsibility to ensure accuracy. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company. Not all services are covered by your insurance plan, many insurance companies arbitrarily select certain services they will not cover. Any charges not paid by insurance are your financial responsibility. We accept cash, personal checks, Visa, MasterCard, Discover Card, and Care Credit financing. For more info about Care Credit please talk to our financial coordinator when you check out. Any balances over 90 days will be charged 1.5% monthly interest. Balances over 120 days will be turned over to collections.

Appointments for planned dental treatment require payment/ (or co-payment after insurance estimate) at least 24 hours in advance to confirm appointment reservations. We reserve the right to charge for appointment no shows or short notice cancellations. We require 24 hours notice to cancel or reschedule appointments.

***The following discounts and incentives are offered, these are subject to change at any time without notice, 5% maximum discount. Not to be combined with any other discounts offers, or coupons.**

- **Full Payment 5% Courtesy Discount - Payment in full at time of service Cash, Check, Only. No insurance/Care Credit discount.**
- **Active Service Member 5% Courtesy Discount - Applicable for members of the armed service, fire/police department, and teachers.**
- **Senior Citizen 5% Courtesy Discount - Applicable for patients 65 and older. Cash or Check only. Not to be combined with other offers.**

I have read and understand the Financial Policy of Anchorage Midtown Dental Center.

***X*____ *Date:* ____________________**

Notice of Privacy Practices - Please Read and Sign

I understand that as part of my healthcare, Anchorage Midtown Dental Center originates and maintains health records describing my health history, symptoms, examination test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among other health professionals who contribute to my care, a source of information for applying my diagnosis and information for my bill, a mans by which a third party payer can verify that services billed were actually provided, etc. I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this condensed form I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I provided. I understand that I have the right to object to the use of request restrictions as to how my health information may be used or disclosed, carry out treatment, payment, or healthcare operations and that the organization will not require agreeing to the restrictions requested. I understand that I may revise this consent in writing, except to the extent that the organization has already transaction in reliance thereon.

I have read and request the following restrictions to the use or disclosure of my health information:

***X*____ *Date:* ____________________**

General Consent for Treatment

I understand that dentistry is not an exact science and reputable practitioners cannot guarantee results. Despite the most diligent care and precaution, unanticipated complications or results, although rare, may occur. These complications include, but are not limited to; soreness, bruising, swelling or difficulty opening, post operative bleeding, temporary numbness in the lip or chin and in rare cases permanent numbness following injection with local anesthetic. Teeth that have been treated with fillings or crowns may be sensitive to biting and temperature changes. Dentures full or partial can be difficult and do not function like natural teeth. Sore spots, altered speech and difficulty eating are common complications. Dentures will loosen over time and will need to be replaced every 5 to 10 years. Placing implants to support or retain dentures will help increase the function and longevity. Root canals are effective approximately 90% of the time, complications can occur from the treatment including separation of endodontic files and reamers, and post operative flare ups. Additional surgical procedures may be necessary following root canal treatment, in some cases the tooth may need to be removed. During the course of treatment antibiotics, analgesics, and other medications may be prescribed. These drugs can cause allergic reactions including hives or anaphylactic shock. It is my responsibility to seek emergency treatment in the event of a serious reaction. In order to formulate an accurate treatment plan we will need to take x-rays and perform an oral examination. No treatment will be rendered without the appropriate x-rays or exam. You will have the opportunity to ask any questions about the procedure, alternatives will be presented as well as risks of treatment.

I have read and understand the General Consent and give my consent to proceed with treatment.

***X* ____ *Date:* ____________________**

Referral Program

We value your referrals! Refer any new patient to our practice and receive a $30 dollar gift card, **limit 1 card per new family,** plus receive 1 Ticket for a Quarterly Drawing (ex: Flat screen TV). Not redeemable for cash. New referred patients must attend the first appointment.

- Silver Club - Refer 10 Patients within 3 years. Receive an additional $100 dollar gift card plus $250 off any dental service.
- Gold Club - Refer 25 patients within 3 years. Receive an additional $250 dollar gift card plus $500 dollars off any dental service