Aleknagik Milton
DENTAL CENTER

DATE_____/_____/

Full Legal Name: _____ Preferred Name: _____

Male: ____ Female: ____ Birthdate: _____ Marital Status: _____ SSN:_____/_____/_____

Wireless Phone: _____ Home Phone: _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

Mailing Address: _____ Unit #_____ City: _____ State: _____ Zip Code: _____

May we email you? Yes / No **May we text you? Yes / No**

Reason for today's visit?

When was your last visit to the dentist? If not here, where did you go?

Who is responsible for the account? (example: self, parents, spouse)

How did you hear about us?

Are you an Alaskan resident? If not, how long are you in Alaska for?

Emergency Contact: _____ Relationship: _____ Phone #:_____

GENERAL CONSENT TO TREATMENT

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. Despite the most diligent care and precaution unanticipated complications or results, although rare, may occur. These complications include but not limited to; soreness, bruising, swelling, difficulty opening jaw, post-operative bleeding, temporary numbness in the lip or chin, and in rare cases permanent numbness may occur following injections with local anesthetic. Teeth that have been treated with fillings or crowns may be sensitive to percussion and temperature changes. Full dentures or partial dentures can be difficult and do not replace natural teeth but do replace for not having teeth. Sore spots, altered speech and difficulty eating are common complications of dentures full or partial. Dentures ***will*** loosen over time and will need to be replaced every 5 to 10 years. Placing implants to support or retain dentures may help increase the function and longevity. Root canals are effective an estimated 90% of the time, complications may occur from the root canal treatment. Such as; separation of endodontic files and you may experience 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 may cause allergic reactions including hives and or anaphylactic shock. It is your 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 any procedures rendered. Alternative plans for treatment may be presented to you as well as risks of treatment.

Initial all statements that apply:

_____ I authorize you to leave detailed messages regarding my appointments on my voicemail or answering machine

_____ I authorize you to discuss my appointments with my spouse or (insert name)_____

Patient/ Guardian Signature:_____ Date:_____/_____/_____

Patient's Name: _____ Phone: (_____)

_____

Pharmacy: _____ Physician's Name:

CURRENT MEDICATIONS or Write N/A if Not Applicable

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES or Write N/A if Not Applicable

1. _____
2. _____
3. _____

Do you have or have you had any of the following:

- Are you in good health? Yes No
- Prosthetic joint of any kind? Yes No

  Specify year & location: _____
- Artificial Heart Valve/Transplant? When?_____ Yes No
- Pacemaker - When?_____ Yes No
- Previous Infective Endocarditis? Yes No
- Heart Attack / Heart Disease? When?_____ Yes No
- Chest Pain (Angina)? Yes No
- Kidney Disease/ Dialysis? Yes No
- Diabetes? Type? _____ Yes No
- COPD / Emphysema? Yes No
- Currently Use Tobacco? Yes No
- Asthma? Yes No
- Lung Disease? Yes No
- Stroke? When?_____ Yes No
- High Blood Pressure Yes No
- Chemotherapy / Radiation / Cancer? Yes No

  If so, When? _____
- Taken Bisphosphonates Drugs? (Bone) Yes No
- Bleed or Bruise Easily? Yes No
- Coumadin (Warfarin), Plavix? Circle One Yes No
- Pregnant? If so, how many weeks?_____ Yes

Do you have or have you had any of the following:

- Seizures? - When? _____ Yes No
- Fainting Spells? Yes No
- Psychiatric Care? Yes No
- Diagnosed w/ Depression? Yes No

  If so, when? _____
- Sinus Problems? Yes No
- Rheumatic Fever? Yes No
- Stomach Ulcers / GI Disease? Yes No
- Herpes? Yes No
- Hepatitis? A, B, C? Yes No
- HIV?

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.

Signature: _____ **Date:** _____

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GENERAL CONSENT FOR TREATMENT

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Signature: _____ Date: _____

OFFICE FINANCIAL POLICY

Your payment is due at the time of scheduling your appointment

We accept cash, personal checks, all major credit cards, Wells Fargo and Care Credit financing. 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. 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. Insurance quotes are ALWAYS AN ESTIMATE. Not all services are covered by your insurance plan, many insurance companies arbitrarily select certain services they will not cover. We require payment up front, unless other financial arrangements are made in advance. Additionally, we provide financing with third party finance companies and their interest rates are subject to change. Please refer to the third parties specific application process for more detailed information. Any balances over 90 days will be charged 18% monthly interest. Balances over 120 days will be turned over to collections. We reserve the right to charge $120.00 for appointment no shows or cancellations with less than 48 hours of advanced notice. The following discounts and incentives are offered, these are subject to change at any time without notice, 5% maximum discount.

- Full Payment 5% Courtesy Discount - Payment in full prior to scheduled appointment Cash or Check only. No insurance, Care Credit, Wells Fargo or Credit Card discount
- Service Members, fire department and police officers - 5% Discount applicable for co-payments
- Senior Citizen 65 and older - 5% Discount applicable for Cash, Check or Credit card payments towards co-payments

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Initial all statements that apply:

_____ I authorize you to discuss appointments with my spouse as listed on my patient information

_____ I authorize you to communicate with the additional following individuals:

_____

By signing below, I acknowledge that I have received, or have had the opportunity to receive, a copy of the

Official Notice of Privacy Practices from

Anchorage Midtown Dental Center, LLC. (Copies can be obtained at the front desk)

Signature:

_____Date:_____