Anchorage Midtown
DENTAL CENTER

DATE_____/_____/_____

Legal Full Name: _____ **Preferred Name:** _____

Male____ **Female**_____ **Birthdate:** _____ **Marital Status:** _____ **SSN:** _____/_____/_____

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

Email: _____ **Cell Phone: (**_____**)** _____**Home: (**_____**)** _____

Emergency Contact:_____**Relationship:** _____ **Phone: (**_____**)** _____

May we email you? Yes / No May we Text You? Yes / No

Employer:_____ **Occupation:** _____ **Phone: (**_____**)** _____

Who is responsible for your account: _____ **Relationship to You:** _____

How did you hear about us? _____ **Reason for today's visit:** _____

Last dental visit (if not with us):_____ **Name of last Dental Office:** _____

Primary Insurance:

Subscriber's Name: _____**Relationship to You:** _____

Subscriber's Mailing Address: _____ **Unit #**_____**City:**_____**St:**_____**Zip:**_____

Subscriber's SSN: _____/_____/_____ **Subscriber's DOB:** _____/_____/_____

Subscriber's Employer: _____**Employer's Phone: (**____**)** _____

Dental Insurance Company: _____**Insurance Phone Number:** _____

Group Number: _____ **Member/Subscriber ID:** _____ **Military Rank:** _____

Secondary Insurance:

Insured's Name: _____**Relationship to You:** _____

Insured's Mailing Address: _____ **Unit #**_____**City:**_____**St:**_____**Zip:**_____

Subscriber's SSN: _____/_____/_____ **Subscriber's DOB:** _____/_____/_____

Insured's Employer: _____**Employer's Phone: (**___**)** _____

Dental Insurance Company: _____**Insurance Phone Number:** _____

Group Number: _____ **Member/Subscriber ID:** _____ **Military Rank:** _____

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	No
• Possibly Pregnant?	Yes	No
• Rheumatoid Arthritis	Yes	No

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?	Yes	No
• Intake of Alcohol?	Yes	No
• Drinks per day _____per week_____		
• Thyroid / Adrenal Disease?	Yes	No
• Steroid Therapy?	Yes	No
• Dry Mouth?	Yes	No
• Excessive Thirst/Urination?	Yes	No
• TMD / Pain in Jaw Joints?	Yes	No
• Drug Rehab / Pain Management?	Yes	No
• Cocaine in the last 24 hours?	Yes	No
• Has a physician recommended Antibiotic prior to dental treatment?	Yes	No
• Other (list) _____		

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:** _____

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 an estimated 90% of the time, complications can occur from the treatment including separation of endodontic files 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 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 the procedure. Alternatives will be presented as well as risks of treatment.

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; this information may not be accurate and it is your responsibility to ensure accuracy. We will bill your insurance for you as a courtesy, however, it does not guarantee payment from your insurance company. 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 at time of service Cash or Check only. No insurance, Care Credit, Wells Fargo or Credit Card discount.
- Service Member 5% Courtesy Discount - Applicable for members of the armed service, fire department and police department.
- Senior Citizen 5% Courtesy Discount - Applicable for patients 65 and older.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Initial all statements that apply:

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

_____ 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: _____