

# Alaska Center for Dentistry, Anchorage, PC

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C. Michael Sage, DDS

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## Patient Information

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
Address: \_\_\_\_\_ City / State / zip: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Male  Female  Minor  Single  Married  Divorced  Widowed  Separated   
Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Would you like a confirmation call one day prior to your appointments? Yes  No   
Where do you prefer to receive calls? Work  Home  Car   
When is the best time to reach you: Time \_\_\_\_\_ Days \_\_\_\_\_  
In the event of an emergency, who should we contact? Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party

Who is responsible for the account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_ Driver's License: \_\_\_\_\_  
Address: \_\_\_\_\_ City / State / Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Home Phone: \_\_\_\_\_

For your convenience, we offer the following methods of payment. Please check the option you prefer.

**Payment in full at each appointment by:**

Cash  Personal Check  Credit Card: Visa  MC

### SERVICE CHARGE:

if fees for services rendered are not paid within 90 days from the date of service, a finance charge of .88% per month on the unpaid balance will be assessed. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the amount or any future outstanding account balances.

## Authorization & Release

I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination provided for me or my dependents to third party payors and/or other health practitioners. **I understand that I am financially responsible for all charges for treatment provided for me or my dependents.**

Signature of patient (or parent if minor): \_\_\_\_\_ Date: \_\_\_\_\_

*As a courtesy to our patients, we are glad to file your dental claims. You will be reimbursed directly by your insurance company. If you would like our help with your claims, please provide us with the following information:*

### PRIMARY INSURANCE

Name of Insured: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_\_  
SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Ins. Co. Phone: \_\_\_\_\_

### SECONDARY INSURANCE

Name of Insured: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_\_  
SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Ins. Co. Phone: \_\_\_\_\_

Signature (authorization to file insurance) \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_  
LAST FIRST M

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**DENTAL HISTORY**

PLEASE CIRCLE

Do you have a specific dental problem? Describe \_\_\_\_\_ YES NO  
 Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ YES NO  
 Would you describe your present dental health as good? Comments \_\_\_\_\_ YES NO  
 Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ YES NO  
 Do you want to keep your remaining teeth? \_\_\_\_\_ YES NO  
 Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_ YES NO  
 Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ YES NO  
 Do you think you have active decay or gum disease? \_\_\_\_\_ YES NO  
 Do your gums ever bleed? Discuss \_\_\_\_\_ YES NO  
 Do you feel nervous about having dental treatment? \_\_\_\_\_ YES NO  
 Have you ever had a bad experience in a dental office? Describe \_\_\_\_\_ YES NO  
 Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ YES NO  
 Do you ever brux or grind your teeth? Discuss \_\_\_\_\_ YES NO  
 Have you ever had orthodontic treatment (tooth straightening)? \_\_\_\_\_ YES NO  
 Do you ever have clicking, popping or discomfort in the jaw joints? (TMJD)? Discuss \_\_\_\_\_ YES NO  
 Name of previous dentist (optional) \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_ YES NO  
 Date of last full mouth x-rays (16 small films or panoramic) \_\_\_\_\_ YES NO

**MEDICAL HISTORY**

Medical doctor's name \_\_\_\_\_ YES NO  
 Are you under a doctor's care now? Why? \_\_\_\_\_ YES NO  
 Have you been hospitalized or received a blood transfusion? When? \_\_\_\_\_ YES NO  
 Are you taking any medications, pills or drugs? What? \_\_\_\_\_ YES NO  
 Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), phen-fen (phentermine), or Meridia (sibutramine)? \_\_\_\_\_ YES NO  
 Are you allergic to any medications or substances? Please check box below. YES NO  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other? \_\_\_\_\_ YES NO

WOMEN (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives?

Please **CIRCLE** if you have had any of the following: \*If yes to any of the starred conditions, please call prior

to your appointment - Premedication may be required

- |                         |                               |                       |                      |                    |
|-------------------------|-------------------------------|-----------------------|----------------------|--------------------|
| Heart Murmur*           | Shortness of Breath           | Sinus Trouble         | X-ray or Cobalt Tmt. | Drug Addiction     |
| Mitral Valve Prolapse*  | Swelling of Feet/Ankles/Hands | Emphysema             | Chemotherapy/        | Blood Transfusion  |
| Rheumatic Fever*        | Fainting or Dizziness         | Frequent Cough        | Radiation            | Hemophilia         |
| Artificial Heart Valve* | Stroke                        | Lung Disease          | Arthritis/Gout       | AIDS (HIV)         |
| Heart Pacemaker*        | Diabetes                      | Tuberculosis          | Rheumatism           | Venereal Disease   |
| Heart Surgery*          | Excessive Thirst              | Liver Disease         | Pain in Jaw Joints   | Cold Sores         |
| Heart Trouble/Disease   | Artificial Joints/Hips*       | Hepatitis A (infect.) | Cortisone Medicine   | Fever Blisters     |
| High Blood Pressure     | Kidney Trouble                | Hepatitis B (serum)   | Glaucoma             | Herpes             |
| Low Blood Pressure      | Ulcers                        | Yellow Jaundice       | Epilepsy or Seizures | Bruise Easily      |
| Congenital Heart Lesion | Allergies                     | Recent Weight Loss    | Nervousness          | Sickle Cell Anemia |
| Blood Disease           | Scarlet Fever                 | Cancer                | Alzheimer's Disease  |                    |
| Anemia                  | Asthma                        | Thyroid Disease       | Hypoglycemia         |                    |
| Chest Pain              | Hay Fever                     | Parathyroid Disease   | Psychiatric Care     |                    |

Have you ever had any other serious illness not circled above? \_\_\_\_\_ YES NO

Please describe in detail \_\_\_\_\_

Do you wish to talk to the doctor privately about any problem? \_\_\_\_\_ YES NO

History Review and Significant Findings: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
PATIENT SIGNATURE (PARENT OR GUARDIAN)

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Reviewed by: Doctor \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL UPDATES**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states my past and present conditions.

DATE	EXCEPTIONS	DATE	EXCEPTIONS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____