

**Alaska Center for Dentistry, PC**  
418 N. Main Street -Wasilla, AK 99654 – Phone: 907-373-8455

Patient Name \_\_\_\_\_ Legal Name \_\_\_\_\_ DOB \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Lives with (If you are the patient, list your information).

Prefix \_\_\_\_\_ Name \_\_\_\_\_ Legal Name \_\_\_\_\_

Address (Mailing) \_\_\_\_\_ City/ State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Number \_\_\_\_\_

Employer \_\_\_\_\_ Work Number \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ State DL # \_\_\_\_\_

Responsible Party (Whom is responsible for this account?) Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone (HM) \_\_\_\_\_ (Cell) \_\_\_\_\_ (WK) \_\_\_\_\_

Primary Ins. Name \_\_\_\_\_ Employer \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Ins. Phone# \_\_\_\_\_ Group# \_\_\_\_\_ SSN/ID# \_\_\_\_\_

Secondary Ins. Name: \_\_\_\_\_ Employer \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Ins. Phone# \_\_\_\_\_ Group# \_\_\_\_\_ SSN/ID# \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_ Address \_\_\_\_\_

## Medical History:

Are you currently in good health? Yes/No      Are you under the care of a physician? Yes/NO

If yes, please explain \_\_\_\_\_

Name of your MD Doctor \_\_\_\_\_ phone# \_\_\_\_\_

Please list medications you are taking \_\_\_\_\_

Do you have or have you ever had any of the following? (Circle all that apply.)

Heart Disease or Heart Attack	Venereal Disease
High Blood Pressure	Chemo or Radiation Therapy
Heart Murmur or Rheumatic Fever	Drug or Alcohol Addiction/ Treatment
Artificial Heart Valve	Mental Health Treatment
Stroke	Respiratory Disorder or Disease
Anemia/Hemophilia	Ulcers/Excessive Heart Burn
Hepatitis A B or C	Kidney Dysfunction or Disease
Tuberculosis (TB)	Fainting or Dizziness
AIDS/HIV	Asthma
Epilepsy or Seizures	Sinus Trouble or Infections
Diabetes I or II Hypo/Hyperglycemia	Pain or Clicking in the Jaw Joints
Thyroid Dysfunction or Disease	Arthritis (Which Kind?) _____
Allergies/Hives	Cortisone Treatments

Are you currently planning to be or are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what Trimester are you in \_\_\_\_\_. Are you taking birth control pills? Yes/No

Is there any other information about your health that we should know about? \_\_\_\_\_

## Dental History:

Have you ever had an unfavorable reaction to local anesthetic? (Novocain, ect.) \_\_\_\_\_

Have you ever had a problem or unfavorable experience from any dental treatment? No/Yes  
Please explain \_\_\_\_\_.

How long since your last dental exam and cleaning? \_\_\_\_\_ Type of cleaning you had? (Perio Scaling or regular healthy cleaning?) How long since your last X-rays? (Full mouth, ect.) \_\_\_\_\_

Does Dental treatment make you nervous? Yes/NO (If yes would you like to be predated?)  
Yes/NO. If yes, would you like Nitrous Oxide (laughing gas) or Drugs (IV/Oral (Valium)?)

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. I understand that I am responsible for all charges for treatment provided for my dependents or me.

Signature of patient or (Parent of Minor) \_\_\_\_\_ Date: \_\_\_\_\_