Alaska Center for Dentistry, PC
1700 E. Bogard Road Suite 201A Wasilla, AK 99654

Patient Information

Name ______________________________ Prefer to be called ____________________________

Mailing Address __________________________ City ____________ State______ Zip________

Home Phone _________________ Cell Phone ________________ Work Phone _____________

Where do you prefer to receive calls? ☐ Home ☐ Cell ☐ Work

Email address ____

DOB _____________ SSN _________________ Driver's Lic# __________ Male or Female

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name _________________

Employer ___________________________ Occupation ___________________________________

Emergency Contact __________________ Relationship ___________ Phone _______________

Whom may we thank for referring you? ____

Responsible Party (Parent or Guardian of Minors)

Name ___________________________________ Relationship to Patient ____________________

Mailing Address __________________________ City ____________ State______ Zip________

Home Phone _________________ Cell Phone ________________ Work Phone _____________

DOB ______________________ SSN _____________________ Driver's Lic# _____________

Employer ___________________________ Occupation ___________________________________

Insurance

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber's Name ________________________	Subscriber's Name ____________________
Relationship to Patient ____________________	Relationship to Patient __________________
DOB ____________ SSN __________________	DOB ___________ SSN __________________
Employer ________________________________	Employer ______________________________
Occupation ______________________________	Occupation ____________________________
Insurance Company ________________________	Insurance Company _____________________
Insurance Phone # ________________________	Insurance Phone # ______________________
ID # _________________ Group #__________	ID # _________________ Group #__________

Do you have Current Xrays that need to be transferred to our office? ☐ YES ☐ NO

Patient Name ______________________ DOB ____________________

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 Medical Doctor ________________________ Phone # ________________

Please list all medications you are taking _____________________________________

Are you allergic to anything? (medication, food, latex) ____________________________

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

Heart Disease or Heart Attack	Artificial Heart Valve	Artificial Joints
High Blood Pressure	Chemo/Radiation Therapy Yr:___	Pacemaker
Heart Murmur/Rheumatic Fever	Stroke	Anemia/Hemophilia
Hepatitis Type _____	Tuberculosis (TB)	AIDS/HIV
Epilepsy or Seizures	Mental Health Treatment	Venereal Disease
Thyroid Dysfunction/Disease	Ulcers/Excessive Heart Burn	Fainting or Dizziness
Diabetes I or II Hypo/Hyperglycemia	Kidney Dysfunction/Disease	Asthma
Respiratory Disorder/Disease	Cortisone Treatments	Pain/Clicking in Jaw
Heart Valve Disease	Cancer, Type/Yr:________	Circulatory Problems
Cold Sores/Herpes	Alzheimer's Disease	Glaucoma
Drug or Alcohol Addiction/Treatment	Arthritis (Which Kind?) ________	

Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how much per day? ____________

Women: Are you taking Birth Control? ☐ Yes ☐ No   Are you nursing? ☐ Yes ☐ No

Are you currently pregnant or planning to be? ☐ Yes ☐ No ☐ Maybe   What trimester? __________

Any other information about your health we should know about? __________________________

Dental History

Nature of your visit today? ______________ Date of last exam and cleaning? ________________

What dental goals can we help you achieve? ______________________________________

How often do you brush your teeth? ____________________ Floss? ____________________

How many non-water beverages do you consume in a day? ______________________________

Have you ever had an unfavorable reaction to local anesthetic? (Lidocaine, etc.) _______________

Does dental treatment make you nervous? Yes/No If so, circle one: Slightly Moderately Extremely

Would you like to be sedated? Yes/ No If so, what kind? Nitrous (laughing gas), IV, or Oral Valium

I certify the above information regarding myself or my dependents to be accurate and true to the best of my knowledge. I also give authorization to take xrays, study models, photographs or other diagnostic aids to make a thorough diagnosis of treatment needs.

Signature of patient or parent/guardian ___________________________ **Date** ______________

Reviewed by ______________________________________ Date ____________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: ____

Address: ____

Telephone: ____________________ Email: ______________________________

Patient Number: ________________ Social Security Number: ____________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Shauna Sherbahn-Goelz
Telephone: 907-373-8455 Fax: 907-373-8456
E-mail: manager@acdwasilla.com
Address: 1700 E Bogard Rd. Suite 201A Wasilla, AK 99654

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, __________________________ (Print Name), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________________ **Date:** ____________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________

Relationship to Patient: ____

Financial Agreement

Alaska Center for Dentistry, PC
1700 E. Bogard Road Suite 201A
Wasilla, AK 99645
(907) 373-8455

Financial Agreement and Authorization for Treatment

We wish to stress that the Financial Responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. **Your insurance policy is a contract between YOU and YOUR Insurance Company. We cannot guarantee payment of your claim.** If it is not paid, the insurance company should explain to you why it was rejected or downgraded in payment. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you.

We try our very best to get an estimated cost of your dental coverage but it is only that, an estimate. Every policy has different rules and limitations. We bill your insurance as a courtesy to you. If you would prefer to have no financial surprises, you can pay for services in full and we will bill your insurance for your direct reimbursement. Or you can also request a dental treatment preauthorization which takes about 30 days to receive from insurance.
Initials___________

If any overpayment is received it will be refunded to you. Should your account become 60 days past due, an interest charge can be applied to your account.

I hereby authorize the release of any dental or financial information necessary to process claims for services rendered.

In the event legal action should become necessary to collect an unpaid balance for dental services to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper.

I authorize treatment of the named patient and agree to pay all fees and charges for such treatment. I understand that payment is due at the time of service. I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balances on my account. **Initials**_______

I will be responsible for any scheduled appointments and will give 24 hours notice to cancel or reschedule any appointment, or I will be subject to a cancelation fee. **Initials**__________

Patient/Guardian Signature

Witness Signature

Date: ____________________

Signature on File Form

In order for us to accept your insurance as payment, please complete both of the following:

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any **Provider, Insurer or other Organization** to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X____ Date_______________
Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize payment directly to Alaska Center for Dentistry for services rendered.

X____ Date_______________
Signed (patient, parent or legal guardian if minor)

In order to facilitate a speedy check out, Alaska Center for Dentistry will maintain this "signature on file" for you.

☐ **CONTINUOUS AUTHORIZATION TO CHARGE MY CREDIT CARD ON FILE**
I authorize Alaska Center for Dentistry to keep my signature on file and to charge my credit card account listed below for treatment performed in this office on any given date of service. I understand that this authorization will remain in effect unless I cancel this authorization in writing. I also understand that this form is kept in the strictness of confidentiality.

☐ **AUTHORIZATION FOR UNPAID CLAIMS TO CHARGE CREDIT CARD ON FILE**
I authorize Alaska Center for Dentistry to charge my credit card account listed below for the balance of charges not paid by insurance within 45 days that does not exceed the charges of the claim in question. I understand that this authorization will remain in effect unless I cancel this authorization in writing. I also understand that this form is kept in the strictness of confidentiality.

CREDIT CARD

(Circle one) Visa MasterCard Discover American Express

Bank Name:_______________________________________
Credit Card Number:___________________________ Exp. Date__________ V Code____
Printed Name:_______________________________________
Cardholder Signature:_______________________________________

Unless prior financial arrangements have been made, your cc on file will not be charged without verbal authorization first.

Consent to Discuss Patient Information

____________________________	____________________________
Printed Name of Patient	Date of Birth
____________________________	____________________________
Street Address	City, State, Zip
____________________________	
Phone Number	

I permit Alaska Center for Dentistry, their physicians, nurses and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical or dental care:

This authorization is limited to discussions regarding the following medical or dental condition(s)

- ☐ Everything
- ☐ Only Treatment
- ☐ Only Financial

Name	Relationship	Phone Number
1.____________________	____________________	____________________
2.____________________	____________________	____________________

If at any time, I do not want my consent to continue to be permitted, I must notice my Dental Care Provider.

Patient Signature/Parent: ______________________________ Date:____________________

If this release is signed by a representative on behalf of the patient, complete the following:

Representatives Name: ______________________________

Relationship to Patient: ______________________________