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 ________________________