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

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 _____