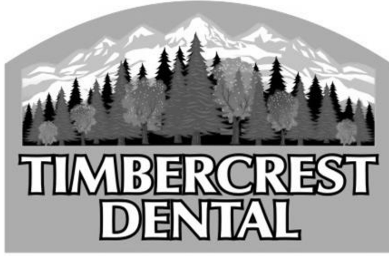

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION

Name_________________________________Preferred Name: ____________________[ ]Male [ ] Female
Last, First
[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Child
Date of Birth: _____/_____/______ Age: ______ SSN: ______________________
Mailing Address: ________________________________City:_______________________State:_____Zip:______
Home Phone :(___)_______________Work :(___)_______________Ext._____ Cell :(___)____________________
Email Address:____
Employer: _______________________________ Occupation: ____
Employer's Address________________________________City:______________State:_______Zip:___________

PERSON RESPONSIBLE FOR ACCOUNT (self if over age 18)

[ ] Same as above Name: _____________________________ Date of Birth:_____/_____/______Relation:________
Billing Address: ____________________________________City:______________ State: ______ Zip: ___________
Home Phone :(___)______________ Work :(___)_______________SSN: _____________________________________

SPOUSE INFORMATION

[ ] Same as above Name: ____ Date of Birth: _____/_____/______
Employer: ____ Work Phone :(___)_______________Ext.___________

DENTAL INSURANCE INFORMATION

Primary Insurance: **If we have copies of your insurance card(s) you do not need to fill out this section.**
Insurance Co. Name: ____ Phone :(___)_______________
Group #:__________________ Subscriber ID: ____
Insured's Name: _____________________________________ Date of Birth: ____/_____/______Relation:________
Insured's SSN: ____________________________ Insured's Employer: _____________________________________
Secondary Insurance:
Insurance Co. Name: ____ Phone :(___)_______________
Group #:__________________ Subscriber ID: ____
Insured's Name: _____________________________________ Date of Birth: ____/_____/______Relation:________
Insured's SSN: ____________________________ Insured's Employer: _____________________________________

EMERGENCY CONTACT

Name: ____ Relation: __________________________________
Home Phone: (___)_______________Cell: (___)_______________

MEDICAL HISTORY INFORMATION

Name of Primary Care Physician: ____ Phone: (___)_____________

Do you have or have you ever had any of the following? Please check those that apply:

[ ] Acid Reflux
[ ] Allergies/Hay Fever
[ ] Allergies/Seasonal
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Breathing Problems
[ ] Cancer
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Diabetes
[ ] Epilepsy or Seizures
[ ] Excessive Thirst
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Disorder-Congenital*
[ ] Heart Infection*
[ ] Heart Murmur*
[ ] Heart Pace Maker*
[ ] Heart Surgery*
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorders
[ ] Mitral Valve Prolapse*
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Sickle Cell Disease
[ ] Sinus Problems
[ ] Stroke
[ ] Surgical Shunt*
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers/Mouth
[ ] Ulcers/Stomach
[ ] Venereal Disease
[ ] Yellow Jaundice

***This condition may require antibiotic premedication for certain dental procedures.**

1. Do you have any health problems that were not listed above or need further clarifications? If yes, explain: ____
____
2. Are you now under the care of a physician? If yes, explain: ____________________________________
____
3. Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain
____
____
4. Are you taking any medications or herbs? If yes, explain: ____________________________________
____
____
5. Are you currently taking bisphosphonate medicine for osteoporosis, or other bone diseases?
[ ] Fosamax [ ]Actonel [ ]Other
____
6. Are you allergic to any medications or substances? [ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine
[ ]Metal [ ]Latex [ ]Other:____
7. Have you used tobacco?
If yes, explain: ____

WOMEN (Please Check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

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 medications change, I will inform the dentist and the staff at the next appointment without fail.

Signature of patient, parent or guardian ______ Print Name ______ Date ______

Paul C. Anderson, DDS
Timothy Mathews, DDS
2270 Nistler Rd.
Delta Junction, AK 99737
Phone (907)-895-4274

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. Our practice depends upon reimbursement from the patient and the insurance company for costs incurred during the visit. Therefore, the patient must consider their financial obligation prior to the visit.

- **Patient's portion is due at the time of service.**
- **We accept cash, check, Visa, MasterCard and Discover cards.**
- **We offer the Care Credit Card, which offers a full range of payment plans, including no interest for 6 months and no upfront costs.**

As a courtesy to our patients we will file your insurance claims for you. Please keep in mind that your insurance is a contract between you and your insurance company and does **NOT** guarantee payment. Our dental practice cannot render services on the **assumption** that our charges will be paid at 100% by an insurance company. We will prepare and file your insurance claims, but ultimately the responsibility is the insured's. If the insurance company does not pay the claim in 60 days the account balance will be due within 10 days of the billing statement. It will then be the insured's responsibility to pursue reimbursement from their insurance company. **Our policy requires payment in full for all services rendered at the time of the visit**, unless other arrangements have been made with our financial coordinator. If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expensed incurred in collecting the account.

Regarding Insurance: Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. Our staff does their best to provide you with accurate insurance coverage estimates based on the information available to us. Many insurance companies will not give out fees until treatment is provided. Reimbursement is ultimately determined when the claim is processed. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

CANCELLATION POLICY

When we make an appointment for you, a room is reserved, your records are prepared, and special instruments are prepared for your visit. Please notify us as early as possible if you are unable to keep your appointment. **A fee of $75.00 will be charged for any appointment broken with less than 24 hours notice. Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

I understand and will comply with the office **Financial Policy**.
I understand and will comply with the office **Cancellation Policy**.

Signature of patient, parent or guardian Print Name Date

AUTHORIZATION AND CONSENT to TREATMENT

General Consent to Treatment

I agree and consent to a dental examination. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize staff to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits to this office.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge that I was given a copy of the practice's HIPAA notice to read. I understand that I may ask questions I might have regarding this notice.

I understand and have been provided with a Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change this notice and practices prior to implementation and will post a copy of the revised notice. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this office is not required to agree to the restrictions requested. I understand I may revoke this consent in writing, except to the extent that this office has already taken action relying on this consent.

I understand and agree to the **Authorization and Consent to Treatment**.
I have read and understand the **Notice of Privacy Practices.**

____

Signature of patient, parent or guardian   Print Name   Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation it was not possible to obtain acknowledgement
- ☐ We weren't able to communicate with the patient
- ☐ Other (please provide specific details)__________________________________

Employee Signature: ____ Date: ________________