



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: _____
Has your insurance changed since your last visit? [] Yes [] No _____

MEDICAL HISTORY INFORMATION

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

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

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