Peninsula Family Dental Center

47707 Judy Lynn Lane, Soldotna, AK 99669 907-283-9125, peninsuladental99669@gmail.com

Patient Information:

Patient Name: ____Preferred Name: ____________________

Birth Date: ____________________Male: _________ Female: __________ Married: ________ Single: _________ Minor: Y N

SS#____ for insurance purposes, kept confidential Driver's License # ______________

Mailing Address: ____City:______________________ State:_________ Zip:_________

Physical Address (if different)_______________________________ City: _____________________ State: _________ Zip: ________

Home Phone #: ____________________Work #:_______________________________ Cell #: ______________________________

E-Mail address: _______________________________________ Best Way to reach you: ____________________________________

Employer: ____

Emergency Contact: ____ Phone # ____

Other family members seen by us: ____

How did you hear about us? ____

Parent/Guardian(if patient is a minor) or Person Responsible for Account:

Name: ____ Relationship to patient: ____________________________

Birth Date: _______________________ SS#______________________________ Driver's License #: __________________________

Address: ____ City: ____________________ State: __________ Zip: __________

Home Phone #: ______________________ Work #: ___________________________ Cell #: ________________________________

Dental Insurance Information (primary):

Policyholder's Name: ______________________________________Birthdate: ______________ SS#_________________________

Insurance Company: ____ Group #: _______________________________

Address: ____ Policyholder's ID #: _____________________________________

Patient Relationship to Policyholder: Self_______________ Spouse ______________ Child ______________ Other__________________

(Secondary):

Policyholder's Name: _____________________________________ Birthdate: ________________ SS#________________________

Insurance Company: ___________________________________Group#: _____________ Policyholder's ID #: ___________________

Address:____________________________________ Employer: ____

Patient Relationship to Policyholder: Self____________ Spouse______________ Child______________ Other_________________

I understand that the information that I have given today is correct to the best of my knowledge.

Patient Signature: ____ Date: _________________________

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Patient Name: ____ Birth Date: ______________________

Do you like your smile? Yes No

What, if anything would you change about your smile? ____

Why have you come to the dentist today? ____

Are you currently in pain? Yes No **Do your gums bleed**? Yes No **How many times a day do you brush**? ______

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes No

Have you ever been diagnosed with Gum Disease? Yes No

Do you need a pre-med before dental appointments? Yes No If yes, How long ago? ___________________

Previous Dentist or Dental Office: _________________________ Last Visit: ______________________________

Physician's Name: ____ Phone # ____________________

☐ Yes ☐ No Is your general health good?

☐ Yes ☐ No Has there been a change in your health in the last year? Explain:____________________________

☐ Yes ☐ No Have you had a serious illness or been hospitalized in the last 3 years? If so, why?________________

☐ Yes ☐ No Are you being treated by a physician now? For what?____________________________

☐ Yes ☐ No Do you have a pain management contract?

☐ Yes ☐ No Have you had problems with prior dental treatment? If so, what happened? ___________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that is my responsibility to inform this office of any changes in my medical status.

Patient Signature: ____ Date: ___________

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Patient Name:____Date of Birth:________________

Are you allergic to any of the following?

Latex: Yes No   Penicillin: Yes No   Aspirin: Yes No   Erythromycin: Yes No   Codeine: Yes No

Tetracycline: Yes No   Ibuprofen: Yes No   Tylenol: Yes No   Sulfa: Yes No   Dental Anesthetics: Yes No

Have you experienced?

☐ Bleeding problems, bruising easily
☐ Blurred Vision
☐ Chest pain or angina
☐ Diarrhea, constipation, blood in stool
☐ Difficulty swallowing
☐ Difficulty urinating, blood in urine
☐ Dizziness
☐ Dry mouth
☐ Fainting spells
☐ frequent urination
☐ frequent vomiting, nausea
☐ Headaches
☐ Jaundice
☐ Persistent cough, coughing up blood
☐ Recent weight loss/gain
☐ Seizures/Epilepsy
☐ Shortness of breath
☐ Sinus problems
☐ Sleep Apnea
☐ Snoring
☐ Swollen ankles

Do you have or have you had:

☐ Anemia
☐ Arthritis, rheumatism
☐ Artificial joint, Joint Replacement
☐ Asthma, TB, Emphysema, other lung disease
☐ Blood transfusion
☐ Chemotherapy/Cancer
☐ Diabetes
☐ Heart Disease
☐ Heart attack, heart defect
☐ Heart Disease
☐ Heart murmurs
☐ Hepatitis, other liver disease
☐ Herpes
☐ High blood pressure
☐ HIV +/AIDS
☐ Hospitalization
☐ Kidney, bladder disease
☐ Low blood pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Prosthetic heart valve
☐ Psychiatric care
☐ Radiation treatment
☐ Rheumatic heart disease
☐ Skin disease
☐ Stomach problems, ulcers
☐ Stroke,hardening of arteries
☐ Surgeries
☐ Thyroid, adrenal disease
☐ Tumors

Do you take or have you ever taken:

☐ Tobacco? How often/How much? ___________________________
☐ Recreation drugs, street drugs? How often/How much? ___________________________
☐ Alcohol? How often/How much? ___________________________
☐Bisphosphonates (Fosamax, Actonel, Boniva, Skelid, Didronel, Reclast/Zometa, etc.)
☐Blood Thinner (Warfarin, Aspirin, Dabigatran (Pradaxa), Rivaroxaban (Xarelto), Apixaban (Eliquis), etc.)
☐ Prescription medication and/or over the counter medications (including aspirin or herbal supplements)

Please List: ____

Women only:

☐ Yes ☐ No Are you currently pregnant or nursing?
☐ Yes ☐ No Taking birth control pills?

All patients:

☐ Yes ☐ No Do you have any other disease or medical problems NOT listed on this form? If so, explain:______________
____

To the best of my knowledge, I have answered each question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient Signature (or Responsible Party Signature):____**Date:**__________________

Dentist Signature:____**Date:**__________________

Consent for services

As a condition of treatment by this office, **<u>all financial arrangements must be made in advance.</u>** The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we **cannot** guarantee what they will pay. **<u>It is our office policy to collect patient's estimated portion at the time of service.</u>**

In consideration for the professional services rendered to me by the practice, I agree to pay the charges for the services at the time of treatment.

Signature: ____ Date: _______________________

Financial Agreement

Please read entire form carefully, then sign and date the bottom.

The following defines the financial policies of the practice.

Payment is due at the time services are rendered

The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out-of-pocket expense may be less than or greater than the amount estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Some insurance plans require the patient to pay only a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for the visit and then reimburse the patient the covered amount. We will work with your plan, and submit the forms necessary to receive the reimbursement as a service to our patients.

Insurance Coverage

We accept many different insurance plans. All plans have a unique schedule of covered services depending on what plan you have or your employer purchased. There is no guarantee that services will be covered. You, or the person responsible for the account, will be responsible for payment of non-covered procedures. There may be additional charges to cover the costs of parts or lab fees, depending on the treatment provided and type of insurance coverage. If you wish, we can send a pre-determination to your insurance carrier. The advantage of this is knowing approximately what your out-of-pocket expenses will be for the procedures. It is NOT a guarantee of payment. The pre-determination takes 4-6 weeks to process.

Major Work

Patients receiving major work, such as crowns, bridges, dentures or bleaching kits must have their portions completely paid off before the work can be delivered or cemented.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We ask that you the patient give us 24 hours' notice of cancellation.

Returned Checks

There will be a returned check fee of $20 for any NSF checks. This fee may increase depending on the bank's charges. The fee will be added to the outstanding balance.

I understand the financial policies of Peninsula Family Dental Center and agree to them

Signature: ______________________________ Date: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ____, have received a copy of this office's Notice of Privacy Practices.

____ ____________________________

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__Other (please specify)

____
____
____