ALCAN FAMILY DENTAL
2819 DAWSON STREET
ANCHORAGE, AK 99503

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. ___ - ___ - ____ Birthdate ___ / ___ / ____

Mailing Address _____ Home Phone ( ) -

City _____ State _____ Zip Code _____

Cell ( ) - Fax ( ) - Email _____

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate ___ / ___ / ____ Social Security No. ___ - ___ - ____

Patient Occupation _____ Employer _____ Work Phone ( ) -

Spouse Occupation _____ Employer _____ Work Phone ( ) -

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
Employee's S.S. No. ___ - ___ - ____	Employee's S.S. No. ___ - ___ - ____

Person responsible for payment: _____

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No ( ) - Work Ph. No. ( ) -

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you have difficulty or
pain when opening (yawning)? ❑ Yes ❑ No
Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No
Difficulty / pain when chewing, talking,
or using your jaws? Teeth? ❑ Yes ❑ No
Do you have noises in your jaw joints? ❑ Yes ❑ No
Pain about the ears, temples or cheeks? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you had a recent injury to your head / jaw? ❑ Yes ❑ No

Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food catch in-between your teeth? ❑ Yes ❑ No
How often do you brush?_____ Floss? _____ ❑ Yes ❑ No
Any difficulty chewing your food? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No
Have you ever been premedicated for dental work? ❑ Yes ❑ No
Do you have frequent Headaches? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? _____

_____

_____

HEALTH HISTORY

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you been hospitalized in the past 2 years? ❑ Yes ❑ No
Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name _____
Address _____ Phone:_____

Are you currently taking any medications / drugs? ❑ Yes ❑ No
If yes, please list: _____
List Medications: _____

_____

_____

_____

Women: Are you pregnant? ❑ Yes ❑ No
Please list any serious medical condition(s) that you have/had:

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Angina Pectoris	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Disease / Attack / Stroke	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	Heart Failure	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease	❑	❑	Allergies / Hives
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Surgery	❑	❑	Ulcers	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Nervousness
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Frequent Headaches	❑	❑	Psychiatric Treatment
❑	❑	**Artificial Heart Valve**	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint	❑	❑	Drug / Alcohol Addiction
❑	❑	Diabetes	❑	❑	X-ray / Cobalt Treatment	❑	❑	**Artificial Joints (Hip, Knee)**	❑	❑	Blood thinner
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever	❑	❑	Splenectomy

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics ❑ Aspirin
❑ Codeine ❑ Latex
❑ Metals / Jewelry ❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

_____

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 it is my responsibility to inform this office of any changes in my medical status. I also give permission to Alcan Family Dental and the staff to use any photos taken for lecturing and continuing education purposes.

Signature _____ Date _____

Medical History Update
(For Office Use Only)

Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____

ALCAN
FAMILY DENTAL

About your Insurance

We understand how important insurance benefits are to you. Your Dentist will be recommending the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions.
Dental insurance is a contract between you and your insurance company. As a courtesy, when you provide your current insurance card billing information, we will assist you with filing your electronic dental insurance claim(s). Your insurance has a yearly maximum, and **anything over that will be your responsibility.** Deductibles, copays, and over maximum insurance must be paid on the date of service. If dental services have been provided for you by another provider within your benefit year those fees will count toward your maximum as well. If you have two insurance policies, not **all policies will cover remaining portions after your primary insurance has paid.**

I acknowledge that I have read and understand this. *Please Initial Here* _____ I don't have dental insurance _____

Financial Agreement

In order to provide you with the highest quality dental care, we provide our patients with *estimates of fees* before dental treatment. Estimated patient copays are due on the date of service. We provide payment options as: Cash, Check, Major Credit Cards and Care credit. For patients with insurance, **if your insurance does not pay the estimated amount, you as a patient, parent and/or guardian are responsible for your account balance.** Any balance beyond 60 days is your responsibility. You will receive monthly statements from us advising you of any unpaid balance on your account and 10% yearly interest may be charged for unpaid balances over 60 days.

I acknowledge that I have read and understand this. *Please Initial Here* _____

Appointment Commitment

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time. **If circumstances occur and it's necessary for you to change your scheduled appointment, we request a 24-hour notice. A no call/no show is not acceptable and may result in a $100 lost appointment fee that must be paid prior to future appointments.** Please be courteous and call us to discuss the best times for scheduling your appointments so we can complete the dentistry you need to keep your teeth healthy.

I acknowledge that I have read and understand this. *Please Initial Here* _____

Consent for Use and Disclosure of Health Information/HIPAA

I, _____, have had the full opportunity to read the Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent for your use and disclosure of my protected health information, to carry out treatment, payment activities and healthcare operations.

* If you are signing for a minor please print their name here: _____

My Personal and Account Information May Be Released to:

1._____ 2. _____

Signature: _____ ***Date:*** _____