ALCAN FAMILY DENTAL
2819 DAWSON STREET
ANCHORAGE, AK 99503

CHILD'S NAME _____ Preferred Name _____

____Male ____ Female. Birthdate _____ Age ____

Mother's Name _____ Birthdate _____ Social Security _____

Mailing Address _____ Home Phone _____

_____ State _____ Zip Code _____

Mother's Occupation _____ Employer _____ Work Phone _____

❑ **Stepmother** ❑ **Guardian** ❑ **Foster**

Father's Name _____ Birthdate _____ Social Security No. _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Father's Occupation _____ Employer _____ Work Phone _____

❑ **Stepfather** ❑ **Guardian** ❑ **Foster**

With whom does this child reside? _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Cell Phone _____ Work Phone _____

Whom may we thank for referring you? _____

MEDIA RELEASE OF LIABILITY

I ❑ do or ❑ do not, hereby grant permission to Alcan Family Dental to use my photograph(s) and/or videos. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images and/or video taken or submitted. Publications may be used for continued education, lecturing as well as in office and online via social media.

PRIMARY DENTAL INSURANCE

Subscriber _____

Employer _____

Insurance ID# _____ D.O.B._____

Employee's S.S. No. _____

Insurance Co. _____ Group#_____

Insurance Phone No. _____

SECONDARY DENTAL INSURANCE

Subscriber _____

Employer _____

Insurance ID# _____ D.O.B._____

Employee's S.S. No. _____

Insurance Co. _____ Group#_____

Insurance Phone No. _____

Please see other side

DENTAL HISTORY

Is this your child's first dental visit? ❑ Yes ❑ No
Previous Dentist's Name? _____
Date of last visit: _____
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? ❑ Yes ❑ No
Has your child ever been premedicated for dental work? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets, or water? ❑ Yes ❑ No

Dr.'s Notes: _____

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized during the past 2 years? ❑ Yes ❑ No
Has your child been under the care of a medical Doctor during the past 2 years? ❑ Yes ❑ No
Is your child currently taking medications? ❑ Yes ❑ No
If yes, please list: _____

Has your child taken any medicine/drugs during the past 2 years? ❑ Yes ❑ No
If yes, please list: _____
Please list any serious medical condition(s) that your child had or has had: _____
Name of physician: _____
Physician Phone#: _____

Dr.'s Notes: _____

PLEASE CHECK "YES OR NO" TO THE FOLLOWING CONDITIONS:

Y N		Y N		Y N		Dr.'s Notes
❑ ❑	Allergies:	❑ ❑	Chemotherapy / Cancer.	❑ ❑	Heart Murmur/Rheumatic Fever	
	Antibiotics_____	❑ ❑	Congenital Heart Defect	❑ ❑	Heart Surgery	
	Aspirin	❑ ❑	Cortisone Medicine	❑ ❑	Hemophilia	
	Latex Y or N	❑ ❑	Cough/Tuberculosis (TB)	❑ ❑	Hepatitis: A B C **(circle one)**	
	Asthma:	❑ ❑	Diabetes	❑ ❑	High/Low Blood Pressure	
	❑ Seasonal	❑ ❑	Down Syndrome	❑ ❑	Hives	
	❑ Exercise induced.	❑ ❑	Emphysema / Asthma	❑ ❑	Kidney Failure/Dysfunction	
	Other: _____	❑ ❑	Epilepsy / Seizure.	❑ ❑	Liver Disease/Yellow Jaundice	
❑ ❑	ADHD/ ADD	❑ ❑	Fainting / Dizzy Spells	❑ ❑	Nervousness	
❑ ❑	Autism	❑ ❑	Fever Blisters/Cold Sores	❑ ❑	Pain in Jaw Joint	
❑ ❑	Blood Transfusion/Anemia	❑ ❑	Frequent Headaches	❑ ❑	Psychiatric Treatment	
❑ ❑	Bruise Easily	❑ ❑	Hay Fever / Sinus Trouble	❑ ❑	Thyroid Disease	

DOES YOUR CHILD HAVE ALLERGIES 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 child's medical status. I authorize the Doctors and/or dental staff to perform the necessary dental services my child may need.

_____ Date: _____
Parent/Guardian Signature

_____ Date: _____
Doctor Signature

Medical History Update

(For Office Use Only)

Date _____ Comments_____
Parent's Signature _____
Date _____ Comments _____
Parent's Signature _____

Date _____ Comments _____
Parent's Signature _____
Date _____ Comments _____
Parent's Signature _____

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:*** _____