DENTAL INNOVATIONS
PATIENT REGISTRATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PATIENT INFORMATION:

Married? ☐ Spouse Name: _____

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Male ☐ Female ☐

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ SSN # _____

Preferred Method of Communication: ☐ Text ☐ Email ☐ Hm Phone ☐ Cell Phone ☐ Wk Phone

Student Status (dependent over 19): ☐ Full Time ☐ Part Time Driver's License #: _____

Emergency Contact (Name and Phone Number): _____

RESPONSIBLE PARTY (if minor or someone other than patient):

First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: _____ Date of Birth: _____ Male ☐ Female ☐

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Check if address and phone # are the same for entire family. ☐

Email: _____ SSN #: _____

Driver's License #: _____

PRIMARY INSURANCE INFORMATION: (if applicable)

Policy Holder Name _____ Date of Birth _____

SSN # _____ Patient Relationship to Insured _____

Insurance Company _____ Employer _____

Policy/Member ID # _____ Group # _____

Ins Company Address _____ City, State, Zip: _____

SECONDARY INSURANCE INFORMATION:

Policy Holder Name _____ Date of Birth _____

SSN # _____ Patient Relationship to Insured _____

Insurance Company _____ Employer _____

Policy/Member ID # _____ Group # _____

Ins Company Address _____ City, State, Zip: _____

SIGNATURE: _____ **DATE:** _____

Medical History

Patient Name: Birthdate: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Medical Doctor: _____ Phone: _____

Are you under a physician's care now? ☐Y ☐N

Have you ever been hospitalized or had a major operation? if Yes.... _____

Tobacco use? If so, what kind and how much? _____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐Y ☐N _____

Are you allergic to any of the following?

☐ Anesthetic ☐ Codeine ☐ Metal ☐ Latex ☐ Sulfa

☐ Aspirin ☐ Ibuprofen ☐ Iodine ☐ Penicillin ☐ Other: _____

Unusual reaction to dental injections? _____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Kidney Problems
☐	☐	Anaphylaxis	☐	☐	Excessive Thirst	☐	☐	Liver Disease
☐	☐	Artificial Heart Valve	☐	☐	Heart Attack/Failure	☐	☐	Low Blood Pressure
☐	☐	Artificial Joint	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse
☐	☐	Cancer	☐	☐	Heart Pacemaker	☐	☐	Osteoporosis
☐	☐	Chemotherapy	☐	☐	Heart Trouble/Disease	☐	☐	Pain in Jaw Joints
☐	☐	Chest Pains	☐	☐	Hepatitis A, B, or C	☐	☐	Pregnancy
☐	☐	Cold Sores/Fever Blisters	☐	☐	Herpes	☐	☐	Radiation Treatments
☐	☐	Congenital Heart Disorder	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Convulsions	☐	☐	Hypoglycemia	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Irregular Heartbeat	☐	☐	Tuberculosis
						☐	☐	Tumors or Growths

Have you ever had any serious illness not listed? if Yes..... _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: _____

Signature of Responsible Party

Informed Consent to Proceed

I authorize Dental Innovations and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitive reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____ Date: _____

If minor (Guarantor) signature: _____ Date: _____

Guarantor name: _____

FINANCIAL AND CANCELATION POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. Please understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for the cost of any and all services rendered.

PAYMENT

Full payment is due at the time of service. If insurance benefits apply, your estimated patient responsibility amount is due at the time of service.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office is happy to assist in contacting your insurance company for pre-treatment estimates, upon your request. It is impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits you have. If you have any questions concerning coverage or estimates for services, it is your responsibility to contact your insurance company for answers prior to treatment. Please be aware some or perhaps all of the services provided may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. Again, based on ***estimated*** insurance coverage, your patient responsibility amount is due at the time of service.

WE ACCEPT CARE CREDIT

An option for payment is Care Credit. Care Credit has offered interest-free payment plans of up to 24 months and payment plans with interest for terms up to 60 months – any plan is subject to their terms and conditions. Our practice accepts Care Credit but we have no influence on their promotions or terms. Please apply with Care Credit directly on their website (carecredit.com) or with them on the phone at 1-800-677-0718.

CANCELATION POLICY & MISSED APPOINTMENTS

When you make an appointment, our dental professional reserves time on their calendar for you. Please be respectful to keep the appointment or provide notice of cancellation at least 48 hours in advance. When an appointment is canceled without 48 hours' notice or the patient does not show, the valuable time for that appointment is lost. The loss of valuable time not only prevents the doctor from providing care to other patients, but it also creates a delay in your care. **If 48 hour notice is not given, please be aware you will be charged a $50 fee for each broken appointment**. This fee is not covered by insurance and is the responsibility of the patient. Please help us service you better by keeping scheduled appointments.

PATIENT PHOTO and INFORMATION RELEASE

I hereby authorize Dental Innovations to take photographs, slides and/or videos of my face, jaw and teeth. I understand that the photos, slides and/or videos will be used as a record of my care and may be used for educational purposes in lectures, demonstrations, advertising and professional publications, including website publication. I further understand that the photos, slides and/or videos used may include my name or other identifying information. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ I **CONSENT** to having my name, photos, slides and/or videos released

_____ I **CONSENT** to having only my photos, slides and/or videos released

PATIENT/RESPONSIBLE PARTY: _____

RESPONSIBLE PARTY SIGNATURE: _____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____

Please Print Name

_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Dental Innovations
3161 E. Palmer-Wasilla Hwy. Suite #5
Wasilla, AK 99654

Patient name_____ **Date**_____

We would like to take this opportunity to welcome you to Dental Innovations!

Please take a moment to tell us how you learned about our practice. If more than one applies, please check all.

_____Friend/Family Member:

Name_____

_____Internet Search

_____Website (www.dentalinak.com)

_____ Advertisement:

_____Post card _____Google Ad

Referred by:

_____Other Dental Office _____

_____Physician or other health care professional referral

Name_____

_____Other

Please explain_____