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 # _____

How did you here about us? ☐ Internet Search ☐ Family/Friend _____ ☐ Other: _____

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: Enter none if you do not have any. (if applicable)

Policy Holder Name _____ Date of Birth _____

Policy Holder's SSN # _____ Patient Relationship to Insured _____

Insurance Company _____ Employer _____

Policy/Member ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION:

Policy Holder Name _____ Date of Birth _____

SSN # _____ Patient Relationship to Insured _____

Insurance Company _____ Employer _____

Policy/Member ID # _____ Group # _____

SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICIES

Patient Name: _____ Birthdate: _____

Responsible Party Name: _____

- If proof of insurance/eligibility cannot be provided, payment will be due in full.

- Any deductibles, copay, or coinsurance are due on the date of service.

- Medical insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, “usual and customary” charges, etc.

- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you are in need of an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full or reviewed for collections.

- Delinquent account (>90 days) is subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged to Dental Innovations by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic.

- Dental Innovations will charge a fee of $30.00 for any checks returned as NSF. The patient’s account will be flagged that only cash or credit card payments will be accepted due to the NSF.

- 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.

Today's Date: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

INFORMED CONSENT to PROCEED

Patient Name: _____ Birthdate: _____

Responsible Party Name: _____

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.

Today's Date: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULY.

Patient Name: _____ Birthdate: _____

Responsible Party Name: _____

I hereby give my consent for dental Innovations to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices posted in the office describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dental Innovations reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Dental Innovations may call/mail/email my home me and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out payment and treatment operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

By signing this form, I am consenting to allow Dental Innovations to use and disclose my PHI to carry out payemtn and treatment operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Dental Innovations may decline to provide treatment to me.

Date: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

PATIENT PHOTO and INFORMATION RELEAS

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 and/or videos released

☐ I DO NOT consent to having my name, photos, slides and/or videos released. _____

Signature

RELEASE OF INFORMATION

I authorize Dental Innovations to verbally discuss my dental records with the persons named below. I may revoke this authorization in writing at any time in writing.This is not an authorization to release printed medical records.

Name: _____ Name: _____

Date _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

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

DENTAL
INNOVATIONS
PERSONABLE - PREVENTIVE - CARING

Food Is Medicine - Root Cause Questionnaire

Patient name_____ DOB:_____

Section 1: Diet & Nutrition

1. **How many meals and snacks do you eat per day?**

   1 meal 2 meals 3 meals Snacks between meals (specify):

2. **How often do you consume the following? (Circle frequency: Daily / Weekly / Occasionally / Never)**
   - Sugary drinks (soda, sweet tea, juice) D / W / O / N
   - Processed carbs (crackers, chips, white bread) D / W / O / N
   - Candy/gum (with sugar) D / W / O / N
   - Dried fruit or sticky snacks D / W / O / N
   - Alcohol D / W / O / N
   - Fresh vegetables D / W / O / N
   - Whole fruits D / W / O / N
   - Dairy (cheese, yogurt) D / W / O / N
   - Water D / W / O / N
   - Fermented foods (sauerkraut, kimchi, kefir) D / W / O / N

3. **Do you consume anything acidic regularly (e.g., lemon water, vinegar, energy drinks)?**

   Yes specify: No

4. **Do you eat or drink anything before bed without brushing after?**

   Yes No

Section 2: Oral Hygiene Habits

5. **How many times a day do you brush your teeth?**

   0 1 2 3+

6. **Do you floss daily?**

   Yes No Occasionally

7. **Do you use any of the following?**

   Mouthwash brand/type:

   Tongue scraper Toothpaste with fluoride

   Water flosser Toothpaste without fluoride

Section 3: Lifestyle & Habits

8. **Do you smoke or vape?** No Yes, how often: _____

9. **Do you chew gum or suck on mints?** No Yes, are they sugar-free? Yes No

10. **Do you grind or clench your teeth?** Yes No Not sure

11. **Do you breathe through your mouth while sleeping or during the day?** Yes No Not sure

12. **Do you suffer from dry mouth?**

    Yes No Occasionally

    If yes, list known causes (medications, health conditions):

    _____

    _____

    _____

Section 4: Medical & Wellness Factors

13. **Are you taking any medications that may reduce saliva flow?**

    Yes No If Yes, list: _____

    _____

14. **Do you have any systemic conditions (e.g., diabetes, autoimmune disease) that may affect oral health?**

    Yes No If Yes, specify: _____

    _____

15. **Do you experience frequent acid reflux or heartburn?**

    Yes No

16. **What are your personal health and nutrition goals?**

    _____

    _____

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name Relationship to patient

Dental Innovations
1680 N Peck St
Wasilla, AK 99654

Release of Records Authorization

I hereby authorize release of my Dental records to:

Dental Innovations

office@dentalinak.com

Phone: 907-357-5214

Fax: 907-357-5213

Please include:
Xrays, History, Chart Notes, Patient Demographics (including Insurance information).

Name and phone number of Office to release information:

_____

This Authorization is valid for 1 year from date below.

I understand that I may revoke this authorization at any time by providing written notification.

Patient Name: Date of Birth:

Patient Signature:_____

Date: _____