Please take your time to fill out these forms completely. The more we learn about you the better care we can provide.

Patient Information

Today's Date: _____

Legal First Name: _____Middle Initial: _____ Last Name: _____

I prefer to be called (Nickname, etc.): _____ □ Male □ Female □ Other: _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Number: (_____)_____-_____ □ Home □ Cell □ Work □ Other: _____

Alternate contact number: (_____)_____-_____ □ Home □ Cell □ Work □ Other: _____

Email: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____

Emergency contact name: _____

Relationship: _____ Phone Number: (_____)_____-_____

Whom may we thank for referring you: □ Company Webpage □ Facebook □ Instagram □ Army □ Air Force
□ Family/Friend: _____ □ Other: _____

Dental History

Reason for today's visit:_____

Are you currently in Pain? □ Yes □ No

If so, please describe: _____

Do you have any dental problems now? □ Yes □ No

If so, please describe: _____

Have you ever had trouble with previous dental treatment that you would like us to know about? □ Yes □ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

(If you don't know the dates of the following, take your best guess: 6 months, 1 year, 5 years, 20 years, never)

Date of last dental exam: _____ Date of last cleaning: _____ Date of last x-rays: _____

Procedure(s) done at last dental appointment: _____

Previous Dentist: _____ Previous Dentist Phone number: (_____) _____

Why are you changing dentists: _____

How often do you have dental examinations? _____ How often do you floss? _____

How often do you have dental cleanings? _____ How often do you brush your teeth? _____

What type of bristles do you use: □ Hard □ Medium □ soft

What other dental aides do you use? (Electric toothbrush, water flosser, etc.): _____

Do you require antibiotics before dental treatment? □ Yes □ No

Are you on any blood thinners? □ Yes □ No

Do your gums ever bleed? □ Yes □ No

Have you noticed any mouth odors or bad taste? □ Yes □ No

Do you bite your lips or cheeks frequently? □ Yes □ No

Do you have frequent headaches? □ Yes □ No

Do you clench or grind your teeth? □ Yes □ No

Do you still have your wisdom teeth? □ Yes □ No

Do you currently have any of the following:

□ Loose teeth
□ Broken teeth
□ Lost or broken fillings
□ Lost or broken crowns/bridges
□ Sensitivity when biting
□ Sensitivity to hot
□ Sensitivity to cold
□ Sensitivity to sweets/sugar
□ Food collection between teeth
□ Sores in your mouth

Have you ever had:

Periodontal disease/gum treatment: □ Yes □ No
Orthodontic treatment (braces, etc.): □ Yes □ No
Oral surgery (wisdom teeth extraction, etc.): □ Yes □ No
A bite plate or night guard: □ Yes □ No
Discomfort/popping in your jaw joint (TMJ/TMD): □ Yes □ No
Your teeth ground or bite adjusted? □ Yes □ No
Serious injury to the mouth or head: □ Yes □ No

If you said yes to any of the previous questions, please describe:

_____

Is there anything else about your dental past you would like us to know?

_____

Treatment Consent

I consent to treatment which is advisable and agreeable to both myself and the dentist knowing that certain rare complications may occur. These may include:

- Injury to adjacent restorations, teeth or other tissues
- Trimus: a prolonged stiffness of muscle(s)
- Fistula: small openings between the mouth and sinus following the removal of upper teeth
- Bone fractures
- Paresthesia: a nerve involvement that may result in numbness of the chin, tongue, teeth, lips, or gums
- Dry socket

I understand that there isn't a guaranteed outcome for any treatment. I realize that additional procedures may become an apparent need during treatment and allow the dentist to utilize his/her best judgment.

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

Permission to release private health information

□ Please do not share dental information

I hereby give permission for the following people to have access to my private health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission for the above listed people to have access to my records including but not limited to records, diagnosis, recommended treatment, dates of any past or present treatment, and all financial records associated with past or present treatment. I acknowledge that this permission is optional and can be revoked at any time in writing by me. I understand that this permission is in addition to the office's existing permissions as explained in the office's privacy practices and shall remain in effect until revoked.

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

MIDNIGHT SUN DENTAL
ANCHORAGE & EAGLE RIVER

Medical History

Within the last 2 years have you had any hospitalizations, illnesses, or operations? □ Yes □ No

If yes, please describe: _____

Hospital or Physician: _____ Phone: (_____)_____

Are you currently taking any medications? (Include regular doses of aspirin or over-the-counter medications): □ Yes □ No

If yes, please List: _____

(Use the back of this page if you need more room, or if you have a current list ask the front desk to take a copy)

WOMEN: Are you currently taking birth control: □ Yes □ No

Are you pregnant? □ Yes □ No □ Maybe Due Date: _____ Are you nursing? □ Yes □ No

MEN/WOMEN: Please check any of the following issues:

□ Acid Reflux/GERD
□ AIDS/HIV
□ Alcohol/Drug Abuse
□ Allergies or Hives
□ Anemia
□ Arthritis/Rheumatism
□ Artificial Heart Valve
□ Artificial Bones/Joints
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Bruise Easily
□ Cancer/Chemotherapy
□ Chest Pain
□ Circulatory Problems
□ Cold Sores/Herpes
□ Colitis
□ Contact Lenses
□ Cortisone Medicine
□ Cough, persistent
□ Diabetes
□ Diet (Special/Restricted)
□ Difficulty Breathing
□ Emphysema
□ Epilepsy or Seizures
□ Fainting or Dizzy Spells
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack, year: _____
□ Heart Disease
□ Heart Surgery, year: _____
□ Heart Pacemaker
□ Heart Murmur
□ Hemophilia/Abnormal Bleeding
□ Hepatitis A B C (circle)
□ High Blood Pressure
□ High Cholesterol
□ Hospitalized for Any Reason
□ Jaundice
□ Kidney Disease/Trouble
□ Liver Disease/Trouble
□ Low Blood Pressure
□ Lupus
□ Malignant Hyperthermia
□ Mitral Valve Prolapse
□ Nervousness/Anxiety
□ Neurological Disorders
□ Psychiatric/Psychological Care
□ Radiation Therapy
□ Respiratory Disease/Trouble
□ Rheumatic/Scarlet Fever
□ Shingles/Chicken Pox
□ Sickle Cell Disease/Traits
□ Sinus Trouble
□ Smoking Habit (Tobacco, marijuana, etc.)
□ Snoring/Sleep Apnea
□ Stomach Problems/ Ulcers
□ Stroke
□ Swollen Ankles
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis (TB)
□ Tumors
□ Other: _____

Are you aware of having any allergic or adverse reactions to any of the following medications:

Aspirin	□ Yes □ No	Iodine	□ Yes □ No	Sedatives	□ Yes □ No
Codeine	□ Yes □ No	Jewelry/Metals	□ Yes □ No	Sulfa Drugs	□ Yes □ No
Anesthetics (i.e. Novocain)	□ Yes □ No	Latex	□ Yes □ No	Tetracycline	□ Yes □ No
Erythromycin	□ Yes □ No	Penicillin or other antibiotics	□ Yes □ No	□ other: _____	

If yes, please describe: _____

Please list any medical conditions that you have had that are not listed above: _____

_____

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

Insurance Information

□ No Insurance

By checking this box, I acknowledge that I have no insurance and that all costs are to be paid by me in full at the time of service.

Primary Insurance

Subscriber's Name: _____ Subscriber DOB: _____

relationship to patient: _____

Subscriber Social security number and/or Insurance ID number: _____

Subscriber Employer: _____ Occupation: _____

Insurance Group Name: _____Insurance Group #: _____

Insurance Company: _____

Insurance mailing address: _____

Insurance City: _____ Insurance State: _____ Insurance zip code: _____

Insurance Phone number: (_____)_____ Electronic payer number: _____

Secondary Insurance

Subscriber's Name: _____ Subscriber DOB: _____

relationship to patient: _____

Subscriber Social security number and/or Insurance ID number: _____

Subscriber Employer: _____ Occupation: _____

Insurance Group Name: _____Insurance Group #: _____

Insurance Company: _____

Insurance mailing address: _____

Insurance City: _____ Insurance State: _____ Insurance zip code: _____

Insurance Phone number: (_____)_____ Electronic payer number: _____

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payment on your behalf. Any portion of the charges not covered by the insurance is ultimately your responsibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know any and all limitations associated with your insurance policy. Failure to obtain a referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

Privacy Practices Acknowledgement and Receipt

I, _____, have reviewed a copy of the office's privacy practice and have asked any questions I may have. **You may refuse to sign this acknowledgment**

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

For office use only:

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgment 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: _____

Office Policies

Welcome to our office and thank you for choosing our office to serve your dental needs! We are dedicated to providing the highest quality dental care and services to our patients. We ask that you take a couple minutes to thoroughly read over our office policies. If you have any questions, please do not hesitate to ask.

Appointments:

We see patients on an appointment basis and strive to serve walk-in patients when time allows. We consider an appointment to be a commitment between our office and our patient. We are counting on you to be here, on time for your scheduled appointment. If an appointment is canceled or missed without a 24-hour notice we may apply a charge of $99 for a hygiene appointment and $199 for a doctor appointment at our discretion. If a sedation appointment or an appointment with our surgeon is missed or canceled without 48-hour notice, the fee charged will be $150 per hour. If this fee is applied, all previously scheduled appointment will be canceled until the fee is paid in full. Once you have paid this fee you will have the option to reschedule any canceled appointments. For a new patient who no-shows, we will be unable to re-appoint you. If multiple appointments are missed, we may have no choice but to dismiss you from our practice. If you have extenuating circumstances, we are unaware of please call and let us know. We would be happy to reverse any charge that was applied inappropriately.

Regular visits:

Regular care is very important in preventing cavities and maintaining long-lasting dental health. We encourage our patients to return for their recommended visits and will inform you when you are due for your next visit at the end of each appointment. We may contact you via mail, email, text and/or telephone to ensure you are aware that you are due for your regular preventive care.

Emergencies:

If you have an emergency, please call the office right away and we will do everything possible to get you in at the earliest opportunity. If we are out of the office or it is after hours, we have an answering machine with instructions on how to reach one of our providers.

Please understand we try to keep your waiting time to a minimum and we know your time is valuable. Sometimes there are circumstances out of our control that dictate a waiting time longer than usual. When this happens, we try to give our patients a courtesy call to let them know there may be an additional waiting time. Please make sure we have current contact information for you on file so that we may contact you when needed.

I have read and understand the office policies listed above and I have had the opportunity to ask any questions. I agree to comply with the policies above.

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

Financial Policies

When you are in the middle of treatment for a dental problem, it is easy to forget that a dental office is also a business. We understand that. We also want you to understand that an important part of any business is collecting payment for the services that are provided. We have created this financial policy to help alleviate any miscommunications regarding our billing practices. Please let us know immediately if you have any questions.

This is an agreement between our office as creditor/practice, and the patient/debtor named on this form. In this agreement the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to our office.

Types of insurance:

Contracted: We are participating providers with several insurance companies. Every policy is different and even though we are participating providers there are some policies that limit the reimbursement paid to us. It is your responsibility to be familiar with your insurance coverage and to determine whether or not we are the appropriate type of participating provider for your policy.

Non-Contracted: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payment on your behalf. Any portion of the charges not covered by the insurance is ultimately your responsibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know any and all limitations associated with your insurance policy. Failure to obtain a referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

Statements:

If you have a balance on your account, we will send you a statement. These statements go first to the email on file, if that email is not opened within 7 days or there is no email on file they will go out in the mail. Please make sure your contact information is up to date with our office. The amount shown as your balance is due immediately.

Payment options:

Estimated amounts not covered by insurance are due the date services are rendered. There are NO exceptions unless pre-arrangements have been made ***and*** there is a signed treatment plan on file. Any insurance claim remaining unpaid by 90 days from the date of service is patient responsibility and will be due immediately.

If you have insurance:

1. You pay your deductible and any estimated co-pay on the day of service. This can be paid in cash or credit card.
2. You choose to pay your treatment in full by cash or credit card and have your insurance company send payments on your behalf to you.

If you don't have insurance:

1. You pay by cash or credit card on the day treatment is rendered
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
3. We accept CareCredit with options starting at 6 months no interest if paid in full, on approval with CareCredit. CareCredit is a third-party lender and is not an in-house finance company.

Fees and Past Due Accounts:

A late fee of ten dollars ($10) per month may be applied to accounts that are not paid within twenty-five (25) days of the statement.

A finance charge will be imposed on each item of your account that has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at a monthly percentage rate of one percent (1%) per month, or at an annual percentage rate of twelve percent (12%) per year. You also agree to pay all attorney fees and cost of collection incurred if your account is not paid as agreed.

A missed appointment fee of ninety-nine ($99) for a hygiene appointment and one hundred and ninety-nine ($199) for a doctor appointment when an appointment is either abandoned (no-call, no-show) or canceled within 24 hours of the appointment date without a valid reason. We charged one hundred and fifty dollars ($150) per hour for sedation appointments or appointment with our surgeon when an appointment is either abandoned (no-call, no-show) or canceled within 48 hours of the appointment date

without a valid reason. This fee is not covered by any insurance. Any appointments scheduled after the fee is applied to your account will be canceled until paid in full.

Patients missing an excessive number of appointments will be dismissed from our practice

Credit Balances and refunds

Occasionally an insurance company will pay more than we estimate on your behalf. If this occurs, we will issue you a refund check to the address on file (Please make sure you keep your contact information up to date). If you have a balance of less than ten dollars ($10) this will remain on your account for future treatment unless a refund is requested by you.

Workers Compensation/Personal Injury

We require full payment up front unless other arrangements have been made. If a third-party is supposed to cover your treatment, they can reimburse you directly. We will be happy to provide detailed invoices in these cases.

Credit History/Waiver of Confidentiality

You give us permission to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. You understand that is this account it submitted to an attorney or collection agency, if we litigate in court, or if your past-due status is reported to a credit reporting agency, any treatment at our office becomes a matter of public record.

Divorce

In case of divorce or separation, the party responsible for the account initially remains responsible for the account afterwards. The parent authorizing treatment for a child will remain responsible for any subsequent charges. If the divorce decree requires the other parent to pay for part or all of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring records

You must sign a written request if you want copies of your records and/or x-rays sent to another office. By doing this, you authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization, you authorize us to receive such information.

Co-Signature

If this or another financial policy is signed, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____

Patient consent for electronic communication

Preferred contact method

___Email

___Text

___Phone call

Email Address:_____

Phone Number: (_____)_____-_____

Consent to email, please initial the following:

_____ I am responsible for updating my email address with the office staff

_____ I am able to receive information electronically and store it securely away from any publicly accessible computers.

_____ I can withdraw my consent at any time for electronic communication by calling the office staff

Patient name: _____ Legal Guardian: _____

Patient or legal guardian signature: _____ Date: _____