ADVANCED FAMILY DENTAL CARE

Dr. Dustin Wilde

PATIENT INFORMATION

Date_____

NAME (Last)_____(First)_____(Intitial)_____
Address_____ZIP_____
Home Phone:_____BusinessPhone:_____Cell_____
Date of Birth___/___/___Sex: M F Married____Single_____SS#_____
Occupation_____Employer_____
Address_____
Other family members seen by us:_____
Previous Dentist_____Last Visit_____
Spouse Name _____Work Phone_____
Whom may we thank for referring you?_____

PRIMARY INSURANCE

Insurance Co Name_____Address_____
Phone#_____Group#_____ID#_____
Subscriber_____Relation_____Date of Birth_____
SS#_____Subscriber's Employer_____

SECONDARY INSURANCE

Insurance Co Name_____Address_____
Phone_____Group#_____ID#_____
Subscriber_____Relation_____Date of Birth_____
SS#_____Subscriber's Employer_____

EMERGENCY CONTACT: Name_____Relation_____
Home #_____Work_____Cell_____

MEDICAL HISTORY

Name_____Date_____

What is your general state of health? Excellent___Good___Fair___Poor_____
Name/address/phone number of physician_____
Have you been under the care of a physician in the past year?_____
Have you had major surgery in the past 3 year?_____
If female: Are you Pregnant? (Yes No) Nursing? (Yes No)Are you taking Birth Control? (Yes No)
Any Dental Problems or questions?_____
Do you have any of the following:

YES/NO	YES/NO	YES/NO
( ) ( ) Epilepsy/ Seizures	( ) ( ) Bruise/ Bleed Easily	( ) ( ) Venereal Disease
( ) ( ) Fainting/ Dizziness	( ) ( ) Heart Problems	( ) ( ) Diabetes
( ) ( ) Stroke	( ) ( ) Chest Pain/ Angina	( ) ( ) Thyroid Disease
( ) ( ) Persistent Cough	( ) ( ) High Blood Pressure	( ) ( ) AIDS/ HIV+
( ) ( ) Emphysema/ Bronchitis	( ) ( ) Rheumatic Fever	( ) ( ) Arthritis
( ) ( ) Tuberculosis/ PPD+	( ) ( ) Heart Murmur	( ) ( ) Artificial Joints
( ) ( ) Asthma	( ) ( ) Mitral Valve Prolapse	( ) ( ) Cancer
( ) ( ) Sinus Problems	( ) ( ) Congenital Heart Lesions	( ) ( ) Chemotherapy
( ) ( ) Anemia/ Sickle Cell	( ) ( ) Heart Surgery	( ) ( ) Radiation Therapy
( ) ( ) Hepatitis A, B, C	( ) ( ) Artificial Heart Valves	( ) ( ) Organ Transplant
( ) ( ) Liver Disease	( ) ( ) Pacemaker	( ) ( ) Tobacco Use
( ) ( ) Pneumonia	( ) ( ) Fibromyalgia	( ) ( ) Dry Mouth
( ) ( ) Nervous/ Anxious/Panic Attacks	( ) ( ) Kidney Problems	

Do you have any condition, disease or problem not previously listed?_____
_____
_____

DRUG ALLERGIES:

YES/NO	YES/NO	YES/NO
( ) ( ) Aspirin	( ) ( ) Erythromycin	( ) ( ) Tetracyclin
( ) ( ) Codeine	( ) ( ) Dental Anesthetics	( ) ( ) Other
( ) ( ) Penicillin	( ) ( ) LATEX	

Any not listed:_____
_____
_____

Please list all medications you are taking, including over the counter drugs and herbs:

Medication: Dosage: Times/Day
_____
_____
_____
_____

To the best of my knowledge the above is true and correct.
Advanced Family Dental Care 3500 LaTouche Suite 200, Anchorage AK 99508 (907)561-1330
FOR UPDATE PLEASE SIGN AND DATE_____

So that we may provide you with the best possible care, please complete this information form:

Do you have a history of:

Bleeding Gums ( )
Broken/ Chipped Fillings ( )
Cavities ( )
Food Traps ( )
Loose Teeth ( )
Missing Teeth ( )
Periodontal/Gum Disease ( )
Tender/Swollen Gums ( )
Worn Teeth ( )
Orthodontics ( )
- If so, how long ago? _____
- How long was treatment? _____

Do you now have any of the following:

Fixed Bridge ( )
Full Denture ( )
Implants ( )
Loose/Broken Fillings ( )
Removable Partial ( )
-If so, are you comfortable with your replacements? _____

Account Responsibility

I understand the Advanced Family Dental Care will assist me in billing my primary, and secondary, insurances. I also understand, that regardless of what my insurance pays, I am responsible for the bill for all dental treatment. If my insurance doesn't pay, or doesn't pay within 90 days, I also understand that the entire account balance will be due, and payable, by me. Furthermore, I have been notified that Advanced Family Dental Care is not an agent, or broker, for any dental insurance I may have. The insurance company is a separate entity; that this dental office will bill for me, but I understand that Advanced Family Dental Care cannot guarantee coverage or benefits for the treatment that I may receive.

I hereby authorize that insurance payments are to be paid directly to Advanced Family Dental Care. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations rendered, to my insurance company. I also understand that I am responsible for any fees incurred if this account is sent to a collection agency.

Signature _____ Date_____

Printed Name_____

Advanced Family Dental Care; 3500 LaTouche Suite 200, Anchorage, AK 99508 (907)561-1330

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

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)

_____

_____

_____