WELCOME TO

ADVANCED FAMILY DENTAL CARE

Dr. Dustin Wilde D.M.D

office@afdcalaska.com

PATIENT NAME: _____

Last First Middle Initial

Gender: Male / Female / Other:_____ Marital Status: Married / Single / Child

Social Security #:_____Date of Birth: _____

Email:_____

Address:_____City, State: _____ ZIP:_____

Cell:_____Alternative:_____

Occupation:_____Employer:_____

Other family members seen by us:_____

Previous Dentist:_____Date of last Dental Visit:_____

How did you hear about our office?_____

PRIMARY INSURANCE

Insurance Company Name:_____Address:_____

Phone#:_____Group#:_____ID#:_____

Subscriber:_____Relation:_____Date of Birth:_____

Subscriber's SS#:_____Subscriber's Employer:_____

SECONDARY INSURANCE

Insurance Company Name:_____Address:_____

Phone:_____Group#:_____ID#:_____

Subscriber:_____Relation:_____Date of Birth:_____

Subscriber's SS#:_____Subscriber's Employer:_____

EMERGENCY CONTACT: Name:_____Relation:_____

Home #:_____Work:_____Cell:_____

Do you authorize us to communicate and discuss treatment / account information with another individual, such as spouse or relative?

Name_____ Relationship to patient_____

MEDICAL HISTORY

Reason for Visit/Area of Concern:_____

1. Have you ever been prescribed a **BLOOD THINNER** or **BONE DENSITY** medication? **YES / NO**
2. Have you ever had complications following dental treatment? If **YES**, explain:_____
3. Have you ever been told to take antibiotics prior to dental treatment? If **YES**, explain:_____
4. Have you been under the care of a physician in the past year? If **YES**, explain:_____
   Name of physician_____ Office name:_____Phone #:_____
5. Have you had **major surgery / been admitted to the hospital / needed emergency care** in the past 3 years? If **YES**, circle and explain:_____
6. Do you have any **HEART PROBLEMS**? If **YES**, explain:_____
7. If female: Are you **pregnant / nursing / on birth control**? **YES / NO**

Please check if you have any of the following (select "none" if nothing applies):

☐ **NONE**	☐ Cold Sores/Herpes	☐ Heart Disease	☐ Pacemaker
☐ AIDS/HIV	☐ Congenital Heart Lesion	☐ Heart Murmur/Surgery	☐ Persistent Cough
☐ Anemia	☐ COPD	☐ Hepatitis A/B/C	☐ Pneumonia
☐ Angina/Chest Pain	☐ Diabetes	☐ High Blood Pressure	☐ Radiation Therapy
☐ Arthritis	☐ Dry Mouth	☐ Kidney Problems	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Emphysema/ Bronchitis	☐ Liver Disease	☐ Sinus Problems
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ Mitral Valve Prolapse	☐ Stroke
☐ Asthma	☐ Fainting/Dizziness	☐ Nervous/Anxious	☐ Thyroid Disease
☐ Bruise/Bleed Easily	☐ Fibromyalgia	☐ Organ Transplant	☐ Tobacco Use
☐ Cancer _____		☐ Osteoporosis	☐ Tuberculosis/PPD
☐ Chemotherapy			☐ **Other:**_____

ALLERGIES (select "none" if nothing applies):

☐ **NONE**	☐ Penicillin	☐ LATEX
☐ Aspirin	☐ Erythromycin	☐ Tetracycline
☐ Codeine	☐ Dental Anesthetics	☐ **Other:**_____

Please provide a list of all medications you are currently taking, including over the counter drugs and herbs or list medications on reverse side of this form.

Do you have a history of:

☐ Waking up feeling fatigued	☐ Loose teeth	☐ Tender/Swollen gums
☐ Food Traps	☐ Broken fillings	☐ Worn teeth
☐ Grinding/Clenching	☐ Missing teeth	☐ Orthodontics
☐ Cavities	☐ Periodontal/gum disease	☐ Bleeding Gums

Do you have any of these conditions:

☐ Frequent headaches	☐ Do you wake up with tired or sore jaw?	☐ Full Denture
☐ Migraines		☐ Implants
☐ Head, neck, or shoulder pain	☐ Fixed Bridge	☐ Removable partial

To the best of my knowledge the above is true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment.

Name of Patient_____Date_____

Signature of Patient:_____

(Signature of parent or guardian if patient is under age 18)

ACCOUNT RESPONSIBILITY

Our office strives to provide the best quality of care that we can. We will do our best to help make the billing process easy for our patients, but we will need your help in some cases. It is important that you understand the financial policy in place so we can make a seamless process for our patients. Please read the following financial policy and sign after reading. Please feel free to ask if you have any questions.

Payment is due at the time of service, including any deductibles or co-payments. We accept the following forms of payment:

- Cash, credit card (Master Card, Visa, American Express, Discover), Care Credit, or check

Accounts with a balance over 60 days will be turned over to Cornerstone Collection Agency. We have a payment plan option which can be discussed; however, if payments are missed, your account will be turned over to collections. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be sent to the dentist of your choice.

Insurance Billing – As a professional courtesy, we will be happy to bill your insurance and help you receive your maximum allowable benefits. In order to achieve this, it is important to understand the following:

- It is the patient's responsibility to provide all dental insurance plans at your initial appointment and any former dental visits at other offices that may affect payment.
- Our office staff will calculate a treatment plan for the recommended treatment (if any) based on the information provided by the insurance company upon verifying at your appointment. The quote that will be given is an **estimate** and any remaining balance after the insurance has been billed and has paid their portion, will be the patient's responsibility. Your insurance policy is strictly between you and your insurance company.
- We offer payment plans to help with the copay, but any balance that is not being actively paid for in 60 days will be sent to collection.

Adult Medicaid (21 and over)

- You have a total of **$1150** in dental benefits to use toward dental work each fiscal year (July 1st to June 30th).
- Although we check the amount that you have available for use, it is your responsibility to disclose any other dental visits you have had during the last year, so we can accurately calculate how much have left to utilize. If you do not disclose any former dental visits and the Medicaid office gives us an inaccurate amount that you have available, you will be responsible for the remaining balance on your account.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand that I am responsible for all charges not paid by insurance.

Signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES & PRIVACY PRACTICES ACKNOWLEDGEMENT

If you would like to request a copy, please inform the staff

Under the Health Insurance Portability and Accountability Act of 2013 (HIPAA) we are required to inform you of our privacy policy. We use the personal and health information you provide us to assess your condition and provide treatment within our office. Only the doctor and employees have access to your personal and health information. Your information will not be released to outside parties without your consent or for non-medically related purposes.

We may provide your information to Insurance Plans, 3rd Party Billing Services, or Direct Reimbursement Plans for payment. We may provide your information to collection services. We may provide your information to pharmacies for drug prescription services. We may provide your information to health care providers for consultation purposes, or referrals. If you pay 100% out of pocket you have the right to request that your information not be released to your health plan unless it is necessary for treatment purposes or required by law.

You have a right to a written copy of our privacy policy. You have a right to see, amend, and get copies of you records. You have a right to complain about privacy violation. Your consent must be obtained before the information in your records can be disclosed for treatment, payment, or any health care operations. We will contact you if there is a breach of your Protected Health Information.

If you want more information about our privacy practices, have questions or concerns, or if you are concerned that we may have violated your privacy rights, please contact:

Advanced Family Dental Care at 907-561-1330.

By signing below, you have given us permission to release your personal and health information for health care and dental consultations and referrals, billing, collections, and drug prescriptions. If you refuse to sign, we will not be able to utilize your dental insurance as a means of payment.

Signature: _____ **Date:**_____

If you would like to refuse to sign the acknowledgment, please initial below. If you refuse to sign, you will be required to pay 100% out of pocket and must bill your insurance yourself if you wish to use it.

_____I refuse to sign the "Privacy Practice Acknowledgment"