Patient Information

First Name: _____ MI: ___ Last: _____ Nickname: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Gender: ☐ MALE ☐ FEMALE **Social Security #: _____ Date of Birth: _____**
Address: _____ City, State: _____ Zip Code: _____
Employer: _____
Email: _____ **State ID/Driver's License#**: _____
Emergency Contact Name: _____ Phone Number: _____ Relation: _____

Patient Health History

Do <u>you</u> have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	☐	☐	**Excessive Bleeding**	☐	☐	**Jaundice**	☐	☐	**Respiratory Disorder**	☐	☐
Alcoholism	☐	☐	**Epilepsy**	☐	☐	**Kidney Disease**	☐	☐	**Rheumatic Fever**	☐	☐
Allergies	☐	☐	**Glaucoma**	☐	☐	**Kidney Dialysis**	☐	☐	**Rheumatism**	☐	☐
Anemia	☐	☐	**Hay Fever**	☐	☐	**Latex Sensitivity**	☐	☐	**Scarlet Fever**	☐	☐
Arthritis	☐	☐	**Head injuries**	☐	☐	**Lupus**	☐	☐	**Seizures/Fainting spells**	☐	☐
Asthma	☐	☐	**Hearing Impaired**	☐	☐	**Low Blood Pressure**	☐	☐	**Sinus Problems**	☐	☐
Blood Disease	☐	☐	**Heart Disease**	☐	☐	**Malignancies**	☐	☐	**Stomach Ulcers**	☐	☐
Bone Disease	☐	☐	**Heart Valve, Murmur**	☐	☐	**Mitral Valve Prolapse**	☐	☐	**Stroke**	☐	☐
Cancer	☐	☐	**Hepatitis/Liver Disease**	☐	☐	**Neck & Back Problems**	☐	☐	**Thyroid Disease**	☐	☐
Chemical Dependency	☐	☐	**Type(s)_____**			**Nervous Disorder**	☐	☐	**Tuberculosis**	☐	☐
Chest Pain	☐	☐	**Hepatitis Carrier**	☐	☐	**Pacemaker**	☐	☐	**Tumors or growths**	☐	☐
Circulatory Problems	☐	☐	**High Blood Pressure**	☐	☐	**Prosthetic Joints**	☐	☐	**Ulcers**	☐	☐
Convulsions/Seizures	☐	☐	**Hip/Joint replacement**	☐	☐	**Psychiatric Care**	☐	☐	**Venereal Disease**	☐	☐
Diabetes	☐	☐	**HPV**	☐	☐	**Radiation Treatment**	☐	☐			

Medical History

List any medications you are taking including nonprescription drugs:

Are you allergic to any medications? ☐ **Yes** ☐ **No** *If yes, please list below:*

Are you in good health? ☐ **Yes** ☐ **No**

Date of last medical exam:

Have you ever been hospitalized? ☐ **Yes** ☐ **No** *If yes, what was the problem:*

Do you have any disease/problem you think we should know about?

Have you had a transplant operation that has depressed your immune system? ☐ **Yes** ☐ **No**

Do you smoke or chew tobacco? ☐ **Yes** ☐ **No**

Have you had Heart Surgery? ☐ **Yes** ☐ **No**

Are you now under the care of a medical doctor? ☐ **Yes** ☐ **No**
If yes, please provide the follow information.
Name: **Phone:**

Are you taking blood thinner or bone density medication? (Ex. Fosamax/Plavix/Coumadin/Aspirin) ☐ **Yes** ☐ **No**

Have you ever been told to take pre-medication? ☐ **Yes** ☐ **No**

For Women Only:

Are you taking birth control pills? ☐ **Yes** ☐ **No**

Are you pregnant? ☐ **Yes** ☐ **No**

If yes, what is your expected delivery date:

Are you nursing/breastfeeding? ☐ **Yes** ☐ **No**

Is there a possibility of pregnancy? ☐ **Yes** ☐ **No**

Dental History Information

Date of last dental visit? _____

Name of your previous dentist: _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ☐ Yes ☐ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you or a family member ever been treated for periodontal disease? ☐ Yes ☐ No

Have you ever had complications from an extraction? ☐ Yes ☐ No

Have you ever had a popping or clicking near your ear when you chew? ☐ Yes ☐ No

Are you prone to frequent headaches? ☐ Yes ☐ No

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

Do you have sores, blisters or swelling on your gums lips or cheeks? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have problems with bad breath? ☐ Yes ☐ No

Have you ever had an allergic reactions to a crown, metal fillings or dental appliance? ☐ Yes ☐ No

Have you ever used an electric toothbrush? ☐ Yes ☐ No

Are you teeth sensitive to hot, cold or pressure? ☐ Yes ☐ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

☐ Whiter

☐ Straighter

☐ Close space

☐ Replace silver filling(s) with tooth colored restorations

☐ Repair chipped teeth

☐ Replace missing teeth

☐ Less gum showing

☐ Replace old crowns or caps that don't match

To the best of my knowledge, all of the preceding answers and the information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient: _____Date: _____

Parent/Guardian (if patient is a minor): _____Date: _____

Financial Polices

Please read the following carefully.

At Eagle River Smiles, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. If you have dental insurance, our goal is to utilize those benefits to provide the care you need. With that goal in mind we need your assistance in understanding our financial policies.

1. **A Clear, Written Estimate on the Cost of Treatment**
   Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing so you know what to expect, including your estimated insurance benefits.

2. **Payment is due at the time of service, including any deductibles or co-payments. We accept the following forms of payment:**
   I. Cash
   II. Credit Card- Master Card/ Visa/American Express/ Discover
   III. Care Credit- offers a separate line of credit to cover your entire family's health care needs. (Please ask the office staff for more information)

3. **Insurance Billing**
   You are expected to alert us in full disclosure of all of your dental insurance plans. We will contact your insurance company for you to inquire about your eligibility and benefits, therefore, we will need all of your insurance information at your initial visit. As a courtesy, we will file claims with your insurance company. Ultimately the balance of your account is your responsibility. While we will do our best to obtain accurate information regarding your eligibility and benefits, in rare cases the insurance companies will not always provide us with the most up to date information resulting in inaccuracies. In this scenario we will require you to pay the remaining balance. Your insurance policy is strictly between you and your insurance company, we are not privy to it. We do offer Care Credit as a payment plan option; please feel free to ask any of our staff how to apply. We will allow a 60 day period in which you can pay the remaining balance after we have informed you that it is due. If you do not pay in the allotted time your account will be considered overdue.

4. **Overdue Accounts**
   Accounts with a balance over 60 days will be turned over to Cornerstone Collection Agency. We have a payment plan option through Care Credit if you wish to make use of this. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be referred to a dentist of your choice.

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature of Patient: _____Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

Adult Denali Care/Medicaid:

Please read carefully and sign if you use Denali Care as your insurance

You have a total of $1150 in dental benefits to use toward dental work each Denali Care fiscal year (July 1st – June 30th). Although we check the amount 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 more accurately calculate how much money you have left.

In the event that you do not disclose any dental visits within the last fiscal year and the Denali Care/Medicaid office gives us an inaccurate amount that you have available to use, you are responsible for any difference in cost for services received. Please help us serve you better by letting us know your dental history.

I have read and agree to the terms above. I will disclose to Eagle River Smiles any recent dental visits or appointments made within the last year so that they can ensure I do not have to make any additional payments.

Signature of Patient: _____ Date: _____

Privacy Practice Acknowledgement

Please review the form on clip board before signing below. You may refuse to sign this acknowledgement.

I, _____have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Signature of Patient: _____ Date: _____

Consent Laws for Minors

When a dentist has a minor as a patient and that minor ends up needing restorative work done or treatment outside of a typical cleaning, the dentist must obtain permission from the child's parent or guardian before the treatment can legally begin. Such permission should always be properly documented in the minor's patient chart. Parents who cannot physically bring their child in may send a permission note with the child allowing the dentist to do all necessary work. If the parent has not sent a permission note, and is not with the child at the actual dental office, the dentist must receive permission over the phone from the child's parent or legal guardian before doing any restorative work. In the event the child's parents are divorced, consent must be obtained from whichever parent has legal custody of the child.

Minors Being Left Alone

In some circumstances, a minor may legally be left alone in a dental office while being operated on. For example, if the minor is over the age of 10, they may be left alone during their dental visit. For routine dental procedures, such as fillings, fluoride treatment or cleaning, the minor may be left alone only if the parent or guardian has given permission and will be accessible by phone. Parents and legal guardians may also leave their child alone in a dental office or not be present at all if they contact the dentist ahead of time to arrange for the child to be there unaccompanied by a parent. **Please be aware that dental treatment can change while you are away.**

I have read the above terms/conditions and fully comprehend and will oblige to the best of my abilities. I understand that I am also allowed to bring in written consent, in case of an emergency, for the mentioned minor along with contact information where I am reachable at all times.

Print Child's Name	**Date**
Print Parent/Legal Guardian	**Signature**

Behavior Management - Medicaid Only (Under 21 years):

I understand that various basic behavior guidance methods will be used to help guide the patient through the dental experience and make it a pleasurable one. In the case that those methods are unsuccessful, other advanced behavior guidance methods might be utilized: lap to lap technique, protective stabilization (restriction of patient's movement with wrist bands, by dental personnel, or a combination of both), or oral conscious sedations.

Parent/Legal Guardian Signature	**Date**

Parent/Legal Guardian Consent for Dental Treatment

Print Child's Name _____ Date of Birth _____

Print Child's Name _____ Date of Birth _____

Print Child's Name _____ Date of Birth _____

Print Child's Name _____ Date of Birth _____

Parental/Legal Guardian Contact _____ Phone Number ___(_____)_____-_____

Authorized Caregiver's Information

_____ (____)_____-_____ (____)_____-_____

Caregiver's Name Home Phone Number Cell Phone Number

The above named caregiver shall be authorized to provide consent for all dental treatment, for the above named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

If circumstances permit and/or if Eagle River Smiles needs to contact me, please contact me at the following telephone number:(_____)_____-_____

This consent serves as permission for treatment by Eagle River Smiles for the above named child(ren). This authorization shall be effective until one (1) year from date signed.

OR

Until _____/_____/_____ (list Month, Day, Year)

This authorization will remain in effect until the date stated above- unless I revoke this Authorization in writing and submit it to **Glacier Dental** prior to this date.

_____ _____ _____ _____

Parent / Legal Guardian **(circle one)** Date Witness Date

NOTICE OF PRIVACY PRACTICES

(Please read carefully before signing Privacy Practice Acknowledgment)

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 your records. You have a right to complain about privacy violations. 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: **General Manager for Eagle River Smiles at 907-696-2875.**

By signing the Privacy Practice Acknowledgement, 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 the Privacy Practice Acknowledgement form, we will not be able to utilize your dental insurance as a means of payment.