

## 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 you have a history of:

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

## 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

<u>Date of last dental visit?</u>	Do you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Name of your previous dentist:</u>	Do you have problems with bad breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Reason for today's visit?</u>	Have you ever had an allergic reactions to a crown, metal fillings or dental appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an oral cancer screening? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used an electric toothbrush?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>How often do you floss your teeth?</u>	Are you teeth sensitive to hot, cold or pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums bleed when you brush? <input type="checkbox"/> Yes <input type="checkbox"/> No	On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?	
Have you or a family member ever been treated for periodontal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		1 2 3 4 5 6 7 8 9 10
Have you ever had complications from an extraction? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you could change something about your smile what would it be:	
Have you ever had a popping or clicking near your ear when you chew? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Whiter	
Are you prone to frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Straighter	
Do you grind or clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Close space	
Do you have sores, blisters or swelling on your gums lips or cheeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Replace silver filling(s) with tooth colored restorations	
Have you ever had orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Repair chipped teeth	
	<input type="checkbox"/> Replace missing teeth	
	<input type="checkbox"/> Less gum showing	
	<input type="checkbox"/> 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 Policies

*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 1<sup>st</sup> – June 30<sup>th</sup>). 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.

_____	_____
<b>Print Child's Name</b>	<b>Date</b>
_____	_____
<b>Print Parent/Legal Guardian</b>	<b>Signature</b>

## 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

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### 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)

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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 ( <b>circle one</b> )	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, 3<sup>rd</sup> 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.