ALPINE FAMILY DENTISTRY
BRIGHTER • SMILES • TODAY

PATIENT INFORMATION

Patient name: _____ Preferred Name: _____

Date of Birth: _____ Social Security Number: _____

☐Male ☐Female ☐Married ☐Single ☐Other: _____

Cell phone: _____ Home phone: _____

Work phone: _____ Email address: _____

Full Mailing Address: _____

Occupation: _____ Employer: _____

Who/How did you hear about our office? _____

In case of emergency, whom should we contact?

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Primary Dental Insurance	Secondary Dental Insurance
Policy Holder: _____	Policy Holder: _____
Employer: _____	Employer: _____
ID #: _____ DOB: _____	ID #: _____ DOB: _____
Employee's Social Security #: _____	Employee's Social Security #: _____
Insurance Co: _____ Group #: _____	Insurance Co: _____ Group #: _____
Insurance Phone #: _____	Insurance Phone #: _____

ELECTRONIC COMMUNICATION I agree to allow the team at Alpine Family Dentistry to communicate with me via text message, phone call, and email about appointment reminders, my dental treatment, scheduling, billing, post-op wellness check-ups, etc.
I am aware that although it is unlikely, there is some level of risk that third parties might be able to read unencrypted texts and emails.
I can withdraw my consent to electronic communications by calling: (907) 694-2409.

I am responsible for providing Alpine Family Dentistry any updates to my insurance, as well as my personal, medical, and contact information.

Patient/Parent/Guardian Signature: _____ Date: _____

Medical History

Patient Name: _____

Please check any of the following problems/conditions that apply to you:

Date: _____

AIDS/HIV	YES	NO
Alzheimer's Disease	YES	NO
Anaphylaxis	YES	NO
Anemia	YES	NO
Angina (Chest Pain)	YES	NO
Arthritis	YES	NO
Artificial Heart Valve	YES	NO
Artificial Joints	YES	NO
Asthma	YES	NO
Bacterial Endocarditis	YES	NO
Bruise Easily	YES	NO
Cancer _____	YES	NO
Chemotherapy	YES	NO
Crohn's Disease	YES	NO
Cold Sores	YES	NO
Cortisone Medication	YES	NO
Diabetes, Type:	1 / 2	NO

Drug Addiction	YES	NO
Emphysema	YES	NO
Excessive Bleeding	YES	NO
Fainting/Dizziness	YES	NO
Glaucoma	YES	NO
Heart Conditions	YES	NO
Heart Murmur	YES	NO
Heart Lesions (Congenital)	YES	NO
Heart Surgery	YES	NO
Hepatitis A__ B__ C__ D__	YES	NO
High Blood Pressure	YES	NO
HPV (Human Papilloma Virus)	YES	NO
Hypertrophic Cardiomyopathy	YES	NO
Hypoglycemia	YES	NO
Jaw Joint Pain	YES	NO
Kidney Disease	YES	NO
Liver Disease	YES	NO

Low Blood Pressure	YES	NO
Nervousness/Depression	YES	NO
Pacemaker	YES	NO
Pulmonary Shunts/Conduits	YES	NO
Radiation (Head/Neck)	YES	NO
Renal Dialysis	YES	NO
Rheumatic Fever	YES	NO
Rheumatism	YES	NO
Seizures	YES	NO
Sickle Cell Disease	YES	NO
Sinus Problems	YES	NO
Sleep Apnea	YES	NO
Stomach, Digestive Problems	YES	NO
Stroke	YES	NO
Thyroid Disease	YES	NO
Tuberculosis (TB)	YES	NO

ANY OTHER HEALTH CONDITIONS: _____

Any additional information about conditions (e.g. severity, onset, remission, etc): _____

Medications you are currently taking. (Including supplements)

Drug	Purpose	Drug	Purpose
_____:	_____	_____:	_____
_____:	_____	_____:	_____
_____:	_____	_____:	_____

Are you allergic or had an unfavorable reaction to the following: ☐ No Known Allergies

- ☐ Aspirin
- ☐ Penicillin/Amoxicillin
- ☐ Clindamycin, Azithromycin
- ☐ Codeine
- ☐ Valium
- ☐ Local Anesthetic
- ☐ Nitrous oxide
- ☐ Latex
- ☐ Any other allergies (antibiotics, medications, substances, etc):_____

□ **Yes** □ **No** **Have you ever taken drugs for bone strength or osteoporosis (Boniva, Fosamax, Alendronate, etc)?**

□ **Yes** □ **No** **Has your physician or dentist advised you to take antibiotics before dental treatment? Reason: _____**

□ **Yes** □ **No** **Do you smoke, vape, or use chewing tobacco?**

□ **Yes** □ **No** **Have you had any surgeries or been hospitalized in the last 5 years? Reason:_____**

□ **Yes** □ **No** **Women: Might you be pregnant?** □ **Yes** □ **No** **Breastfeeding?**

Physician's name/office: _____

I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform my dental provider of any changes in medical status.

_____ _____ _____

Patient or Parent/Guardian Signature **Date** **Dentist Signature**

Patient Name: _____

Date: _____

Dental History

Dental concerns or questions you have today:_____

How long has it been since your last dental visit? _____

How often do you routinely see the dentist? □ 3 months □ 4 months □ 6 months □ Not routinely

Please rate your anxiety/fear of dental treatment: □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10

Do you brush: □ Twice a day □ Once a day □ Most days □ Sometimes □ Never

Do you Floss: □ Twice a day □ Once a day □ Most days □ Sometimes □ Never

□ **Yes** □ **No** Have you ever had complications with past dental treatment?

□ **Yes** □ **No** Have you ever had trouble getting numb or had any reaction to anesthetic?

□ **Yes** □ **No** Any problems with your jaw joint? Circle all that apply:

Pain Sounds Limited opening Locking Popping Other: _____

□ **Yes** □ **No** Do you have any problems with sleep, or wake up with an awareness of your teeth or jaw?

□ **Yes** □ **No** Have you ever worn a bite appliance?

□ **Yes** □ **No** Do you frequently get food caught between your teeth (food trap)?

□ **Yes** □ **No** Does your mouth ever feel dry or do you have difficulty swallowing food?

□ **Yes** □ **No** Do your gums bleed or are they painful when you brush or floss?

□ **Yes** □ **No** Have you ever had gum disease or told you have lost bone?

□ **Yes** □ **No** Are your teeth sensitive to (circle all that apply): Cold Hot Chewing Sweets

Is there anything about the appearance of your teeth you would like to change? _____

CANCELATION AND NO-SHOW POLICY

Unconfirmed appointments have an extremely high no-show rate. Therefore, I understand that I must confirm appointments I have made in order to keep my exclusively-reserved time with my dental provider. **If I do not confirm my appointment when contacted, we reserve the right to offer your appointment time to another patient.** **Initials _____**

Last-minute cancelations and no-show rates are so high that our schedule is getting backed up. We kindly request a minimum notice of **48 hours for any appointment you need to cancel**. This allows us time to find another patient who would like that appointment time. If I fail to provide sufficient notice, there may be a **failed appointment fee of $75**. **Initials _____**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities.

I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below (in addition to the allowable disclosures described in the Notice of Privacy Practices):

SPOUSE	☐ YES	☐ NO
ANY MEMBER OF MY IMMEDIATE FAMILY:	☐ YES	☐ NO
OTHER (please specify_____):	☐ YES	☐ NO

Name of Patient/Parent/Personal Representative: _____

Personal Representative's Relationship to Patient (if applicable): _____

Signature of Patient or Personal Representative: _____ Date: _____

FINANCIAL AGREEMENT AND INSURANCE

As a courtesy, we will assist you in filing insurance claims. Many/most insurances have inconvenient stipulations, such as: an annual maximum amount, downgrading coverage for certain procedures, denying claims for arbitrary reasons, a lag in actual available benefits remaining due to slow processing times of other claims, and patient balances despite having two or more insurances, etc.

We are obligated to adhere to the stipulations with which you've agreed in your contract with your insurance provider. Our experienced team will do our best to navigate these policies and fine print with you. We will give you the best possible **estimate** for treatment that we can, but insurance can be unpredictable. **Ultimately, verifying insurance coverage and payment in full is your responsibility.**

Payment is due at time of service. All accounts over 120 days past due may be sent to a collection agency for processing**.** **Initials _____**

General Consent – Alpine Family Dentistry

I understand the purpose of this general consent is to raise my awareness of risks that are commonplace in many dental procedures. I understand that Dr. Brett Kocherhans and his team reserve the right where appropriate (for example: for root canal therapy, extractions and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, dentures, oral and parental sedation) to provide me with more specific informed consent.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. I understand that choosing to do no treatment is always an option, but comes with its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that Dr. Brett Kocherhans and his team will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity. This includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have adverse reaction and I need to fully disclose all of my medications to Dr. Brett Kocherhans and the prescribing pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection. I understand the potential risks, such as allergic reaction to the anesthetic, adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of post-operative infection, nerve damage, and iatrogenic (an injury that might rise from our treatment or advice) injury. In rare cases, the complications from surgery can be permanent, disabling or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have risk or separation or breakage of dental instruments which may become lodged in the gum or other tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact Dr. Brett Kocherhans as soon as possible.

I understand that the practice of dentistry is not an exact science and Dr. Brett Kocherhans offers no guarantees or assurance as per the outcome or results of treatment or surgery.

I have the right to ask Dr. Brett Kocherhans for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that right to its fullest extent if for any reason I feel I am not fully informed about my procedure, the risks of the procedure, and my alternatives to the procedure. I certify that I can read, write, and understand this consent in the English language.

Patient First and Last Name: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____