ALPINE FAMILY DENTISTRY

BRIGHTER · SMILES · TODAY

PATIENT'S NAME _____ Preferred Name _____

❑ Male ❑ Female ❑ Married ❑ Single Social Security No. _____ Birthdate ___/___/___

Mailing Address _____ Home Phone (___) ___-____

City _____ State _____ Zip Code _____

Cell (___) ___-____ Email _____

Patient Occupation _____ Employer _____ Work Phone (___) ___-____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Cell Phone (___) ___-____ Work Phone (___) ___-____

Whom may we thank for referring you? _____

MEDIA RELEASE OF LIABILITY

I ❑ do or ❑ do not, hereby grant permission to Alpine Family Dentistry to use my photograph(s) and/or videos. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images and/or video taken or submitted. Publications may be used for continued education, lecturing as well as in office and online via social media.

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber _____	Subscriber _____
Employer _____	Employer _____
ID # _____ DOB _____	ID # _____ DOB _____
Employee's S.S. # _____	Employee's S.S. # _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Insurance Phone # _____	Insurance Phone # _____

DENTAL HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you have difficulty or pain when opening (yawning)? ❑ Yes ❑ No
Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No
Difficulty / pain when chewing, talking, or using your jaws? Teeth? ❑ Yes ❑ No
Do you have noises in your jaw joints? ❑ Yes ❑ No
Pain about the ears, temples or cheeks? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you had a recent injury to your head / jaw? ❑ Yes ❑ No

Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food catch in-between your teeth? ❑ Yes ❑ No
How often do you brush? _____ Floss? _____ ❑ Yes ❑ No
Any difficulty chewing your food? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No
Have you ever been premedicated for dental work? ❑ Yes ❑ No
Do you have frequent Headaches? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? _____

_____

_____

HEALTH HISTORY

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you been hospitalized in the past 2 years? ❑ Yes ❑ No
Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name _____
Phone: _____

Are you currently taking any medications / drugs? ❑ Yes ❑ No
If yes, please list: _____
List Medications: _____

_____

_____

_____

Women: Are you pregnant? ❑ Yes ❑ No
Please list any serious medical condition(s) that you have/had:

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Angina Pectoris	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Disease / Attack / Stroke	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	Heart Failure (circle one)	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	High / Low Blood Pressure (circle one)	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease	❑	❑	Allergies / Hives
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Surgery	❑	❑	Ulcers	❑	❑	Hepatitis: A B C (circle one)	❑	❑	Nervousness
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Frequent Headaches	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valve	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint	❑	❑	Drug / Alcohol Addiction
❑	❑	Diabetes	❑	❑	X-ray / Cobalt Treatment	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Blood thinner
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever	❑	❑	Splenectomy

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics ❑ Aspirin
❑ Codeine ❑ Latex
❑ Metals / Jewelry ❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

13012 Old Glenn Hwy, Suite 102
Eagle River, AK 99577
907-694-2409

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Alpine Family Dentistry. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Alpine Family Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	**YES**	**NO**
SPOUSE ONLY	**YES**	**NO**
OTHER (please specify)	**YES**	**NO**

Name of Patient or Personal Representative

Signature of Patient of Personal Representative

DATE

Description of Personal Representative's Authority