Alaska Advanced Dentistry

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PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION **PATIENT REGISTRATION**

HOW DID YOU HEAR ABOUT US:		DATE:
LAST NAME:	FIRST:	MI:
PREFERRED NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE :	WORK PHONE :	WORK PLACE:
CELL PHONE:	EMAIL:	
BIRTHDATE:	SOCIAL SECURITY NUMBER:	
MALE FEMALE	MARRIED SINGLE CHILD DIVORCED WIDOWED	

ACCOUNT INFORMATION

Person Financially Responsible for Account

NAME	RELATIONSHIP TO PATIENT	SS#	
ADDRESS	CITY	STATE	ZIP
PHONE: HOME	WORK	CELL	

DENTAL BENEFITS

PRIMARY CARRIER

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATION TO PATIENT
INSURED'S ID NUMBER	INSURED'S SS#

SECONDARY CARRIER

INSURANCE COMPANY	GROUP NUMBER
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATION TO PATIENT
INSURED'S ID NUMBER	INSURED'S SS#

Alaska Advanced Dentistry

Patient Name: **Dental History**

Previous Dentist _____ Phone Number _____

When was your last dental appointment? _____

Do you have any dental problems now? .....Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold?.....Yes No

Sweets? .....Yes No

Biting or Chewing.....Yes No

Have you noticed any mouth odors/bad tastes? .....Yes No

Do you frequently get cold sores, blisters, or any other oral lesions? .....Yes No

Do your gums bleed or hurt? .....Yes No

Have your parents experienced gum disease or tooth loss? .....Yes No

Have you noticed any loose teeth or change in your bite? .....Yes No

Does food tend to get caught between your teeth? ....Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? .....Yes No

Smoke or chew tobacco? .....Yes No

If yes, how much? _____

Feel nervous about having dental treatment? .....Yes No

If so what is your biggest concern? _____

_____

Have any dental fears?.....Yes No

If yes, please explain _____

_____

Are you interested in oral sedation? .....Yes No

Are you interested in teeth whitening? .....Yes No

Have you ever had:

Orthodontic treatment?.....Yes No

Oral surgery? .....Yes No

Periodontal treatment? .....Yes No

Your teeth ground or the bite adjusted? .....Yes No

A bite plate or mouth guard?.....Yes No

A reaction to a local anesthetic? .....Yes No

A serious injury to mouth or head? .....Yes No

If yes, please describe, including cause: _____

_____

If you had a magic wand, what would you change about your smile?

Shape: gap crowding, etc.....Yes No

Tooth length: longer or shorter.....Yes No

Filling: discolored or silver.....Yes No

Crowns/Caps: dull or dead looking.....Yes No

Other: _____

Have you experienced:

Clicking or popping of the jaw? .....Yes No

Pain? (Joint, ear, side of face) .....Yes No

Difficulty opening or closing mouth? .....Yes No

Headaches, neck aches or shoulder aches? .....Yes No

Are you interested in dental care that helps prevent:

Root canals.....Yes No

Broken teeth.....Yes No

Tooth aches.....Yes No

What did you like most and least about your previous dental office? _____

_____

What would you like us to do for you? _____

_____

Is there anything that would prevent you from starting dental treatment at this time? _____

_____

Please complete other side

Patient Name: _____ _____ _____ **Medical History**

Medical Alerts: _____

1. Have you been under the care of a medical doctor during the past two years? .....Yes No
   If yes, for what? _____
   Physician's name _____ Phone # _____
   Address _____ City _____ State _____ Zip _____
2. Are you currently taking any medications, drugs, pills including over the counter medications and herbs?.....Yes No
   If yes, please list: _____
   _____
3. Are you aware of having an allergic (or adverse reaction) to an medication or substance? .....Yes No
   If yes, please list: _____
4. Have you been a patient in the hospital during the past five years? .....Yes No
   If yes, please list reason and length of stay: _____
5. Indicate which of the following you have had or have at the present. (Circle "Yes" or "No" to any that apply)
   Heart surgery, Disease, Attack, Murmur, Mitral Valve, Prolapse.....Yes No

High Blood Pressure	Yes No	Rheumatic Fever	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	Hepatitis A (infectious) B (serum) C	Yes No
AIDS/HIV Positive	Yes No	Respiratory Disease	Yes No
Diabetes	Yes No	Asthma	Yes No
Epilepsy or Seizures	Yes No	Healing Complications	Yes No
Fainting or Dizziness	Yes No	Nervous/Anxious	Yes No
Anemia or blood disorders	Yes No	Psychosis	Yes No

6. Have you ever been treated with Bisphosphonate drugs? (Fosamax, Aredia, or Zometa) .....Yes No
7. Do you have or had any disease, condition, or problem not listed above? .....Yes No
   If yes, please list: _____
8. **WOMEN are** you: **Pregnant?**.....Yes, _____ months No **Nursing?**.....Yes No **Taking birth control pills?** .....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Legal Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Annual Health Review

Date	Initials	Date	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

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How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ /_____ /_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Alaska Advanced Dentistry

Patient Financial Policy

Our office strives to provide the highest quality dental care. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. **Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefits.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. Insurance companies, by Alaska state law, must pay a claim within 30 working days. As an additional courtesy to you, we will allow 60 days for insurance payment on a claim. If payment has not been received, has been reduced, or has been denied by the insurance company, **the patient is responsible to make payment in full.** If your insurance company requires referral and/or preauthorization, you are responsible for obtaining it. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. **Ultimately, you are responsible for the entire cost of your dental treatment.** Any questions or comments regarding your benefits should be directed to your insurance carrier.

1. Payment at the time of service is expected, including the estimated portion of the amount that insurance does not cover. Our office accepts the following: cash, checks, Visa, Mastercard, and Discover.

2. A credit report will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements. Payment history with our office will be taken into consideration when establishing payment arrangements.

3. When a patient's portion cannot be paid at the time of service and payment arrangements have been approved, an interest rate of 10.5% per annum will be charged on all outstanding balances. A written, signed agreement will be completed at our office, which explains the number of payments, interest rate, and total interest to be paid over the term of the agreement.

4. A $30.00 charge will be billed to your account for any check returned by the bank for any reason. We will not accept payments by check from you in the future.

5. Delinquent accounts may be sent to Cornerstone Collection Agency. You are responsible for and agree to pay all collection cost incurred including all lawyer fees and court costs.

6. To obtain a copy of your dental records you must sign a records release form. We will provide one copy of your records for a fee of $35.00.

7. Cancellations or Failures are to be given 2 business days notice before scheduled appointment. Second cancellation or failures will need to pay appointment in full at scheduling which is non-refundable. Failing or short notice cancelling a Saturday appointment will not have the privilege of any further Saturday appointments.

8. Are you interested in outside financial arrangements that may be made available in order to complete your treatment?
   Yes_____ No_____

I have read and understand the financial policy of Alaska Advanced Dentistry and agree to all the terms described in it.

_____ _____

Patient Signature/Guardian Signature Date