Patient Information

Patient Name_____ Date:_____
Last First MI

Preferred Name:_____ Gender:_____ Marital Status:_____
Social Security #_____ Date Of Birth:_____
Phone (Home) _____ (Cell):_____ (Text Messages) ◯ Yes ◯NO
Mailing Address:_____
Street

_____
City State Zip Code
e-mail Address:_____ Employer Name:_____
Work Phone:_____ EXT_____ Referral Source:_____

Please complete the following information for : □ Spouse □ Parent/Guardian

Name:_____
Social Securtity #:_____ Date of Birth _____
Phone (Home):_____ Work: _____ (Cell)_____
Address:_____
Street

_____
City State Zip code

Insurance Information

Primary Insurance

Name of Insured:_____Insured's Date of birth:_____
Last First MI
Insured's Employer Name:_____
Insurance Plan Name:_____
Insurance Address:_____Insurance Phone #:_____
ID#_____Group #
Relationship to Patient: □ Self □ Spouse □ Child

Secondary Insurance

Name of Insured:_____Insured's Date of birth:_____
Last First MI
Insured's Employer Name:_____
Insurance Plan Name:_____
Insurance Address:_____Insurance Phone #:_____
ID#_____Group #
Relationship to Patient: □ Self □ Spouse □ Child

Medical History

Name:_____
Date of Birth:_____Height_____ Weight_____
Physician_____Phone:_____

Do you have any dental concerns at this time?

_____
_____

Yes No Has there been any change in your general health within the past year?
Yes No Have you had a significant weight gain or loss in the past 2 years?
Yes No Are you on a special diet?
Yes No Do you have any health concerns?
My Last physical examination was on _____

Yes No Are you now under the care of a physician?_____ If so for What?_____

Yes No Have you had any serious illness or operation?_____When?_____
If so, what was the illness or operation_____

Yes No Have you been hospitalized or had a serious illness with the past five years?
If so what was the problem?_____

Yes No Do you use tobacco?
Yes No History of alcohol or substance abuse?
Yes No Do you use alcohol daily?

Do you have or have you had any of the following diseases or problems?

Yes No Heart murmurs
Yes No Rheumatic fever or rheumatic heart disease
Yes No Mitral valve prolapsed or other heart valve problems
Yes No Cardiovascular disease (heart trouble, high blood pressure, arteriosclerosis, stroke)
Yes No Have you ever had a heart attack?
Yes No Do you have any artificial joints or other implants?
Yes No Have you had a positive HIV test? (test for AIDS)
Yes No Asthma?
Yes No Hives or skin rash?
Yes No Fainting spells or seizures?
Yes No Diabetes?
Yes No Hepatitis, jaundice, or liver disease?
Yes No Arthritis
Yes No Inflammatory rheumatism (painful, swollen joints)
Yes No Stomach Ulcers
Yes No Kidney trouble
Yes No Tuberculosis
Yes No Venereal disease
If yes, is treatment complete?
Yes No Blood disorder or anemia
Yes No Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
Yes No Have you ever required a blood transfusion? Explain_____
Yes No Have you ever had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips?
Yes No Have you had treatment for periodontal disease?

Yes No Are you currently or have you recently been treated for cancer?
Yes No Are you taking any drug or medicine?
If so, what?_____

Yes No Have you ever taken Zometa?

Are you taking any of the following?

Yes No Antibiotics
Yes No Anticoagulants (Blood thinners)
Yes No Medicine for high blood pressure
Yes No Cortisone (steroids)
Yes No Tranquilizers
Yes No Aspirin or anti-inflammatory (Tylenol, Ibuprofen, etc)
Yes No Insulin, Tolbutamide (Orinase) or similar drug
Yes No Digitalis or drugs for heart trouble
Ye s No Nitroglycerin
Yes No Birth Control Pill
Yes No Other_____

Are you allergic or have you reacted adversely to:

Yes No Local anesthetics
Yes No Penicillin
Yes No Other antibiotics
Yes No Latex gloves or products
Yes No Sulfa drugs
Yes No Other_____

Yes No Aspirin
Yes No Iodine
Yes No Metal or Nickel
Yes No Milk

Yes No Do you or your spouse snore?
If yes, are you interested in addressing your snoring issue?_____
Yes No Have you or your spouse ever been diagnosed with Sleep apnea?
If so, do either of you have a CPAP?_____ Is it used?_____

Yes No Have you had any serious trouble associated with any previous dental treatment?
If so, explain_____

Yes No Do you have any disease, condition, or problem not listed above that you think I should know about?
_____

Yes No Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?

Yes No Do you wear contact lenses?_____ If so, hard or soft_____

Women
Yes No Are you pregnant?

I hereby authorize the release of any information including the diagnosis and records of any treatment or examinations rendered, to my insurance company, or companies. This release is solely for the purpose of facilitating the billing and reimbursement directly to the physician, of insurance benefits under which I am entitled. I am financially responsible for balance due. **We request 24 hours notice for cancelations. A fee may be assessed for broken appointments.**

Dated_____ **Patient signature** _____ _____
Updated_____ **Patient signature** _____ _____
Updated_____ **Patient signature** _____ _____
Updated_____ **Patient signature** _____ _____

FAIRBANKS DENTAL CENTER
3112 Airport Way Ste #1, Fairbanks, Alaska 99709
Ph: (907) 452-1250 ~ Fax: (907) 456-1307

Notice of Privacy Practice

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our legal duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

Uses And Disclosures Of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use our health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to proved you with appointment reminders (such as voicemail, messages, postcards or letters)

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed on the bottom of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (**you must make your writing in request**). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or have to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S Department of Health and Human Services.

Contact Officer: Jennifer Graves ~3112 Airport Way Ste #1, Fairbanks, AK 99709
Telephone: (907)452-1250~Fax: (907)456-1307

Fairbanks Dental Center

3112 Airport Way Ste 1
Fairbanks, Alaska 99709
(Ph)907-452-1250 Fax(907) 456-1307

Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have received a copy of this office's notice of privacy Practices.

Please Print Name:_____
Signature:_____ Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibit obtaining acknowledgement
- ☐ An emergency situation kept us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____