True North Family Dental, PLLC
3708 Rhone Circle
Anchorage, AK 99508
(907) 562-2512

3708 Rhone Circle - Anchorage, Alaska 99508-5089 • Phone: (907) 562-2512 • Fax: (907) 562-6080

## Patient Information

Name: _____ I prefer to be called: _____
Address: _____ City / State / zip: _____
Birthdate: _____ SS #: _____
Employer: _____ Occupation: _____
Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑
Work Phone: _____ Ext: _____ Home Phone: _____ Cell Phone: _____
Would you like a confirmation call one day prior to your appointments? Yes ❑ No ❑
Where do you prefer to receive calls? Work ❑ Home ❑ Car ❑
When is the best time to reach you: Time _____ Days _____
In the event of an emergency, who should we contact? Name: _____
Relationship: _____ Work Phone: _____ Home Phone: _____
Whom may we thank for referring you to our office? _____

## Responsible Party

Who is responsible for the account? _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Driver's License: _____
Address: _____ City / State / Zip: _____
Employer: _____ Occupation: _____
Work Phone: _____ Ext: _____ Home Phone: _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.
**Payment in full at each appointment by:**
**Cash ❑ Personal Check ❑ Credit Card: Visa ❑ MC ❑**

**SERVICE CHARGE:**
if fees for services rendered are not paid within 90 days from the date of service, a finance charge of .88% per month on the unpaid balance will be assessed. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on the amount or any future outstanding account balances.

## Authorization & Release

I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination provided for me or my dependents to third party payors and/or other health practitioners. **I understand that I am financially responsible for all charges for treatment provided for me or my dependents.**

**Signature of patient (or parent if minor):** _____ **Date:** _____

*As a courtesy to our patients, we are glad to file your dental claims. You will be reimbursed directly by your insurance company. If you would like our help with your claims, please provide us with the following information:*

PRIMARY INSURANCE
Name of Insured: _____
Relationship to Patient: _____
Insured's Birthdate: _____
SS#: _____
Employer: _____ Occupation: _____
Insurance Company: _____ Group#: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____

SECONDARY INSURANCE
Name of Insured: _____
Relationship to Patient: _____
Insured's Birthdate: _____
SS#: _____
Employer: _____ Occupation: _____
Insurance Company: _____ Group#: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____

**Signature (authorization to file insurance)** _____

**PATIENT NAME** _____ _____ _____ **DATE** _____
LAST FIRST M

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

## DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Would you describe your present dental health as good? Comments _____ YES NO
Do you brush and floss on a routine basis? Discuss _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
Does food catch between your teeth? Any loose teeth? _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do your gums ever bleed? Discuss _____ YES NO
Do you feel nervous about having dental treatment? _____ YES NO
Have you ever had a bad experience in a dental office? Describe _____ YES NO
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ YES NO
Do you ever brux or grind your teeth? Discuss _____ YES NO
Have you ever had orthodontic treatment (tooth straightening)? _____ YES NO
Do you ever have clicking, popping or discomfort in the jaw joints? (TMJD)? Discuss _____ YES NO
Name of previous dentist (optional) _____ Who referred you to our office? _____ YES NO
Date of last full mouth x-rays (16 small films or panoramic) _____ YES NO

## MEDICAL HISTORY

Medical doctor's name _____ YES NO
Are you under a doctor's care now? Why? _____ YES NO
Have you been hospitalized or received a blood transfusion? When? _____ YES NO
Are you taking any medications, pills or drugs? What? _____ YES NO
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), phen-fen (phentermine), or Meridia (sibutramine)? _____ YES NO
Are you allergic to any medications or substances? Please check box below. YES NO
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other? _____ YES NO
*WOMEN (Please check)*: ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives?

Please **CIRCLE** if you have had any of the following: ***If yes to any of the starred conditions, please call prior to your appointment - Premedication may be required**

| | | | | |
|---|---|---|---|---|
| Heart Murmur* | Shortness of Breath | Sinus Trouble | X-ray or Cobalt Trnt. | Drug Addiction |
| Mitral Valve Prolapse* | Swelling of Feet/Ankles/Hands | Emphysema | Chemotherapy/ | Blood Transfusion |
| Rheumatic Fever* | Fainting or Dizziness | Frequent Cough | Radiation | Hemophilia |
| Artificial Heart Valve* | Stroke | Lung Disease | Arthritis/Gout | AIDS (HIV) |
| Heart Pacemaker* | Diabetes | Tuberculosis | Rheumatism | Venereal Disease |
| Heart Surgery* | Excessive Thirst | Liver Disease | Pain in Jaw Joints | Cold Sores |
| Heart Trouble/Disease | Artificial Joints/Hips* | Hepatitis A (infec.) | Cortisone Medicine | Fever Blisters |
| High Blood Pressure | Kidney Trouble | Hepatitis B (serum) | Glaucoma | Herpes |
| Low Blood Pressure | Ulcers | Yellow Jaundice | Epilepsy or Seizures | Bruise Easily |
| Congenital Heart Lesion | Allergies | Recent Weight Loss | Nervousness | Sickle Cell Anemia |
| Blood Disease | Scarlet Fever | Cancer | Alzheimer's Disease | |
| Anemia | Asthma | Thyroid Disease | Hypoglycemia | |
| Chest Pain | Hay Fever | Parathyroid Disease | Psychiatric Care | |

Have you ever had any other serious illness not circled above? _____ YES NO
Please describe in detail _____
Do you wish to talk to the doctor privately about any problem? _____ YES NO
History Review and Significant Findings: _____

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail

Reviewed by: Doctor _____ Date _____

## MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states my past and present conditions.

| DATE | EXCEPTIONS | DATE | EXCEPTIONS |
|---|---|---|---|
| | | | |
| | | | |
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## Consent to Discuss Patient Information

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Street Address City, State, Zip

_____

Phone Number

I permit True North Family Dental, their physicians, nurses and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical or dental care:

This authorization is limited to discussions regarding the following medical or dental conditions:

_____Everything

_____ Only Treatment

_____ Only Financials

| Name | Relationship | Phone Number |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |

If at any time, I do not want my consent to continue to be permitted, I must notify my Dental Care Provider.

Patients Signature: _____ Date:_____

If this release is signed by a representative on behalf of patient, please complete the following:

Representatives Name:_____

Relationship to Patient: _____

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Teresa R. Wallace

Telephone: 907-562-2512 Fax: 907-562-6080

E-mail: truenorth@mb2dental.com

Address: 3708 Rhone Circle Anchorage, AK 99508

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Financial Agreement

True North Family Dental, PLLC

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## Financial Agreement and Authorization for Treatment

Note: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you. If any overpayment is received, it will be refunded to you. Should your account become 60 days past due, and interest charge can be applied to your account.

I hereby authorize the release of any dental or financial information necessary to process claims for services rendered.

In the event legal action should become necessary to collect an unpaid balance for dental services to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the court determines proper.

I authorize treatment of the named patient and agree to pay all fees and charges for such treatment. Regardless of what my insurance pays, I will pay for the balance in full.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balances on my account.

I will be responsible for any scheduled appointments and will give 24 hour notice to cancel or reschedule any appointment, or I will be subject to a cancelation fee. Initials:_____

Patient/Guardian Signature Date Witness Signature

# Signature on File Form

In order to facilitate a speedy check out, True North Family Dental will maintain this "signature on file" for you. Please select one or both of the following:

☐ **CONTINUOUS AUTHORIZATION**

I authorize True North Family Dental to keep my signature on file and the charge my credit card account listed below for treatment performed in this office on any given date of service. I understand that this authorization will remain in effect for a period of 24 months, unless I cancel this authorization in writing. I also understand that this form is kept in the strictness of confidentiality.

☐ **AUTHORIZATION FOR UNPAID CLAIMS**

I authorize True North Family Dental to charge my credit card account listed below for the balance of charges NOT paid by insurance company within 45 days. I understand that this authorization will remain in effect for a period of 24 months unless I cancel this authorization in writing. I also understand that this form is kept in the strictness or confidentiality.

*In order for us to accept your insurance as a payment, please complete the following:*

**AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize any Provider, Insurer or the other Organization to release any information regarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X_____ _____

Signature (patient, parent or legal guardian if minor) Date

**AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST**: I hereby authorize payment directly to True North Family Dental for services rendered.

X_____ _____

Signature (patient, parent or legal guardian if minor) Date

**CREDIT CARD INFORMATION:**

Please circle one:

Visa Master Card Discover

Bank Name:_____ Card Type: Credit or Check

Account Number:_____ Exp. Date:_____/_____

Vcode (3 digit code on the back of your card)_____ Zip Code:_____

Printed Name (as it appears on your credit card):_____

Cardholder Signature_____