Patient Name: _____
LAST FIRST MIDDLE INITIAL

Gender: ( )Male ( )Female **Marital Status**:( )Married ( ) Single ( ) Child ( ) Other:_____

Social Security #:_____ **Date of Birth:**_____

Address:_____**City, State:**_____**Zip Code:**_____

Phone (Cell #1):_____ **Alternative #:**_____

Employer:_____ **Primary Language:**_____

Email:_____ **Emergency Contact #/Relation:**_____

How did you hear about us? Please check ALL that apply

( ) Google	( ) Facebook	( ) Radio	( ) House Visit – Door to Door
( ) Postcard	( ) Instagram	( ) Event	( ) Event _____
( ) TV	( ) Website	( ) Yelp	( ) Other _____
( ) Anchorage Daily News	( ) Sign on Building	( ) YouTube	( ) Referred by _____

MEDICAL HISTORY

Reason for Visit/Area of Concern:**_____Date of Last Dental Visit:**_____

1. Have you ever been prescribed a **BLOOD THINNER** or **BONE DENSITY** Medication? (Fosamax/Plavix/Coumadin/Aspirin) **YES/NO**
2. Are you **ALLERGIC**: Aspirin/Penicillin/Codeine/Latex/Local Anesthetic/Other: _____ **YES/NO**
3. Have you ever had any complications following dental treatment? **YES,** explain: _____ **YES/NO**
4. Have you been admitted to the hospital or needed emergency care in the past two years? **YES/NO**
   Explain: _____
5. Are you under the care of a physician now? **YES,** explain:_____ **YES/NO**
   Name of Physician:_____ Office Name:_____ Phone #: _____
6. Do you have any **HEART PROBLEMS**: **YES,** explain: _____ **YES/NO**
7. Have you ever been told to take antibiotics prior to dental treatment?: If **YES,** explain: _____ **YES/NO**
8. **FEMALES**-Are you, or could be PREGNANT at this time? **YES, DUE DATE:** _____ **Trimester: 1st 2nd 3rd** **YES/NO**

***Please check ALL that apply: (Please select "None" if nothing applies)**

( ) **NONE**	( ) Epilepsy	( ) Jaundice	( ) Sinus Problems
( ) AIDS	( ) Excessive Bleeding	( ) Kidney Disease	( ) Stomach Problems
( ) Allergies: _____	( ) Fainting	( ) Liver Disease	( ) Stroke
_____	( ) Glaucoma	( ) Low Blood Pressure	( ) Tobacco Use
( ) Anemia	( ) Growths	( ) Mental Disorders	( ) Tuberculosis
( ) Asthma	( ) Heart Murmur	( ) Pacemaker	( ) Tumors
( ) Blood Disease	( ) Hay Fever	( ) Radiation Treatment	( ) Ulcers
( ) Cancer	( ) High Blood Pressure	( ) Respiratory Problems	( ) **OTHER**: _____
( ) Diabetes (Type I/Type II)	( ) High Cholesterol	( ) Rheumatism	_____
( )Dizziness	( ) Hepatitis A/B/C	( ) Recreational Drug	

Provider's Signature:

_____

***Are you currently taking any medications? ( ) NONE ( ) YES**

If **YES,** please list the name(s) and dosage(s):

_____

_____

To the best of my Knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient:_____ **Date:**_____

(If patient is minor, Parent or Guardian)

GLACIER Dental

Financial Policy of Glacier Dental

Our office strives to provide the best quality of care that we can. We will do our best to help make the billing process easy for our patients, but we will need your help in some cases. It is important that you understand the financial policy in place so we can make a seamless process for our patients. Please read the following financial policy and sign after reading. Please feel free to ask if you have any questions.

Payment is due at the time of service, including any deductibles or co-payments. We accept the following forms of payment:

- Cash, Credit Card (Master Card, Visa, American Express, Discover), Care Credit, Lending Club

Accounts with a balance over 60 days will be turned over to Cornerstone Collection Agency. We have a payment plan option which can be discussed; however, if payments are missed, your account will be turned over to collections. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be sent to the dentist of your choice.

Insurance Billing – As a professional courtesy, we will be happy to bill your insurance and help you receive your maximum allowable benefits. In order to achieve this, it is important to understand the following:

- It is the patient's responsibility to provide all dental insurance plans at your initial appointment.
- Our office staff will calculate a treatment plan for the recommended treatment (if any) based on the information provided by the insurance company upon verifying at your appointment. The quote that will be given is an **estimate** and any remaining balance after the insurance has been billed and has paid their portion, will be the patient's responsibility. Your insurance policy is strictly between you and your insurance company.
- We offer payment plans to help with the copay, but any balance that is not being actively paid for in 60 days will be sent to collection.

Adult Medicaid (21 and over)

- You have a total of **$1150** in dental benefits to use toward dental work each fiscal year (July 1st to June 30th).
- Although we check the amount that you have available for use, it is your responsibility to disclose any other dental visits you have had during the last year, so we can accurately calculate how much you have left to utilize. If you do not disclose any former dental visits and the Medicaid office gives us an inaccurate amount that you have available, you will be responsible for the remaining balance on your account.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand that I am responsible for all charges not paid by insurance.

Signature:_____ **Date**:_____

GLACIER Dental

PARENTAL/LEGAL GUARDIAN CONSENT FOR DENTAL TREATMENT

Consent Laws for Minors

When a dentist has a minor as a patient and that minor ends up needing restorative work done or treatment outside of a typical cleaning, the dentist must obtain permission from the child's parent or guardian before the treatment can legally begin. Such permission should always be properly documented in the minor's patient chart. Parents who cannot physically bring their child in may send a permission note with the child allowing the dentist to do all necessary work. If the parent has not sent a permission note, and is not with the child at the actual dental office, the dentist must receive permission over the phone from the child's parent or legal guardian before doing any restorative work. In the event the child's parents are divorced, consent must be obtained from whichever parent has legal custody of the child.

Minors Being Left Alone

In some circumstances, a minor may legally be left alone in a dental office while being operated on. For example, if the minor is over the age of 10, they may be left alone during their dental visit. For routine dental procedures, such as fillings, fluoride treatment or cleaning, the minor may be left alone only if the parent or guardian has given permission and will be accessible by phone. Parents and legal guardians may also leave their child alone in a dental office or not be present at all if they contact the dentist ahead of time to arrange for the child to be there unaccompanied by a parent. **Please be aware that dental treatment can change while you are away.**

Authorized Caregiver's Information

If there are any additional adults (aunts, uncles, grandparents, babysitters, etc.) that are authorized to bring the minor into the office and sign consent for the minor, please provide their information below. By signing below, you are authorizing the named caregiver to provide consent for all dental treatment for the child listed on this form, which may be required in your absence. You are agreeing to pay for all services provided to your child that the caregiver authorized. If you would like the caregiver to be removed from the child's chart, it is your responsibility to inform the staff at the office so they can make note of this in the patient's chart.

_____ _____

Caregiver's Name **Caregiver's Phone Number**

____ No additional caregiver's are needed for my child. I will update the form if one is needed at a later date.

_____ _____

Print Child's Name **Print Parent (or Legal Guardian's) Name**

Signature:_____ **Date**:_____

GLACIER Dental

NOTICE OF PRIVACY PRACTICES & PRIVACY PRACTICES ACKNOWLEDGEMENT

You may refuse to sign this acknowledgement. If you would like to request a copy, please inform the staff.

If you want more information about our privacy practices, have questions or concerns, or if you are concerned that we may have violated your privacy rights, please contact our office.

Under the Health Insurance Portability and Accountability Act of 2013 (HIPAA) we are required to inform you of our privacy policy. We use the personal and health information you provide us to assess your condition and provide treatment within our office. Only the doctor and employees have access to your personal and health information. Your information will not be released to outside parties without your consent or for non-medically related purposes.

We may provide your information to Insurance Plans, 3rd Party Billing Services, or Direct Reimbursement Plans for payment. We may provide your information to collection services. We may provide your information to pharmacies for drug prescription services. We may provide your information to health care providers for consultation purposes, or referrals. If you pay 100% out of pocket you have the right to request that your information not be released to your health plan unless it is necessary for treatment purposes or required by law.

You have a right to a written copy of our privacy policy. You have a right to see, amend, and get copies of your records. You have a right to complain about privacy violations. Your consent must be obtained before the information in your records can be disclosed for treatment, payment, or any health care operations. We will contact you if there is a breach of your Protected Health Information.

By signing below, you have given us permission to release your personal and health information for health care and dental consultations and referrals, billing, collections, and drug prescriptions. If you refuse to sign, we will not be able to utilize your dental insurance as a means of payment.

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Glacier Dental to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Signature:_____ **Date:**_____

If you would like to refuse to sign the acknowledgement, please initial below. If you refuse to sign, you will be required to pay 100% out of pocket and must bill your insurance yourself if you wish to use it.

____ I refuse to sign the "Privacy Practice Acknowledgement"

GLACIER Dental