

GENERAL INFORMATION

Full Name: _____ Nickname: _____ Sex: Male ____ Female ____ DOB: _____

Marital Status: _____ Cell Phone: (____) _____ Home: (____) _____ SSN: ____/____/____

Alternative #: (____) _____ Emergency Contact / Number: _____

Circle any that apply: Parent (If under 18) / Guardian / Power of Attorney: **PRINT NAME** _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ May we send you an email or text reminder? Yes / No

Employer: _____ Address: _____ Phone #: (____) _____

Primary Ins: _____ Member: _____ SSN: ____/____/____ DOB: _____

Secondary: _____ Member: _____ SSN: ____/____/____ DOB: _____

How Long Since Last Dental Visit? _____

How did you hear about us? If referred from a patient, please provide name: _____

HEALTH HISTORY

CURRENT MEDICATIONS

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

DO YOU HAVE ANY ALLERGIES?

1. _____

2. _____

3. _____

Do you have or have you had any of the following? If yes, and there are multiple options, please circle which condition.

1. Are you in good health? Yes No

2. Prosthetic joint of any kind? Yes No
Type of Joint: _____

3. Artificial Heart Valve / Transplant? Yes No

4. Previous Infective Endocarditis? Yes No

5. Heart Attack / Heart Disease / Stroke? Yes No

6. Chest Pain (Angina)? Yes No

7. Diabetes? Type 1 / 2 Yes No

8. COPD / Emphysema? Yes No

9. Currently Smoke? Yes No

10. Asthma / Lung Disease? Yes No

11. High Blood Pressure? Yes No

12. Chemotherapy / Radiation / Cancer? Yes No

13. Taken Drugs for Osteoporosis? Yes No

14. Bleed or Bruise Easily? Yes No

15. Coumadin (warfarin), Plavix, Aspirin? Yes No

16. Intellectually Challenged? Yes No

Please Describe: _____

17. Cocaine in the last 24 hours? Yes No

18. Pacemaker? Yes No

19. Seizures? Yes No

20. Fainting Spells? Yes No

21. Psychiatric Care? Yes No

22. TMD / Pain in Jaw Joints? Yes No

23. Dry Mouth? Yes No

24. Sinus Problems? Yes No

25. Excessive Thirst / Urination? Yes No

26. Kidney Disease / Dialysis? Yes No

27. Stomach Ulcers / GI Disease? Yes No

28. Hepatitis A B or C? **(Circle One)** Yes No

29. Currently on Birth Control? Yes No

30. Thyroid / Adrenal Disease? Yes No

31. Steroid Therapy? Yes No

32. Herpes or HPV ? **(Circle One)**..... Yes No

33. HIV or Aids? **(Circle One)** Yes No

34. Pregnant / Possible Pregnant? Yes No
Due Date: _____

35. Other: (list) _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist at the next appointment.

X _____
PATIENT OR GUARDIAN SIGNATURE **Date**

ADDITIONAL SIGNATURES ON OTHER SIDE

General Consent for Treatment

Despite the most diligent care and pre- caution, unanticipated complications or results, although rare, may occur. These complications include, but are not limited to; soreness, bruising, swelling or difficulty opening, post-operative bleeding, temporary numbness in the lip or chin and in rare cases permanent numbness following injection with local anesthetic. Teeth that have been treated with fillings or crowns may be sensitive to biting and temperature changes. Dentures full or partial can be difficult and do not function like natural teeth. Sore spots, altered speech and difficulty eating are common complications. Dentures will loosen over time and will need to be replaced every 5 to 10 years. Placing implants to support or retain dentures will help increase the function and longevity. Root canals are effective approximately 90% of the time, complications can occur from the treatment including separation of endodontic files and reamers, and post-operative flare ups. Additional surgical procedures may be necessary following root canal treatment; in some cases, the tooth may need to be removed. During the course of treatment antibiotics, analgesics, and other medications may be prescribed. These drugs can cause allergic reactions including hives or anaphylactic shock. It is your responsibility to seek emergency treatment in the event of a serious reaction. In order to formulate an accurate treatment, plan we will need to take x-rays and perform an oral examination. No treatment will be rendered without the appropriate x-rays or exam. You will have the opportunity to ask any questions about the procedure, alternatives will be presented as well as risks of treatment.

I have read and understand the General Consent and give my consent to proceed with treatment.

Signature: _____ **Date:** _____

Notice of Privacy Practices - Please Read and Sign

By signing below, I acknowledge that I have received, or have had the opportunity to receive, a copy of the Official Notice of Privacy Practices Anchorage Dental Group, a division of Mark R. Laurin DDS. (Copies can be obtained from the front desk)

Signature: _____ **Relationship to Patient:** _____ **Date:** _____

Initial all statements that apply:

- _____ I authorize you to leave messages regarding my appointments on my answering machine or voicemail
_____ I authorize you to discuss appointments with my spouse: **PRINT NAME** _____
_____ I authorize you to communicate with the additional following individuals: **PRINT NAMES** _____

By signing this authorization, I understand that this does not authorize release of health information by Mint Dental to any other organization or agency unless I grant further authorization. I also understand that these authorizations may be revoked at any time.

Signature: _____ **Relationship to Patient:** _____ **Date:** _____

Office Financial Policy

Payment for service is due at the time services are rendered. We accept cash, personal checks, Visa, MasterCard, Discover, American Express, Care Credit and Wells Fargo financing. Your insurance policy is a contract between you and your insurance company, we bill your insurance and accept it as a form of payment as a courtesy only and does not relieve you of your financial obligation. Our financial relationship is with you, not your insurance company. We will do our best to provide accurate information about your insurance policy and benefits remaining, however this information may not be accurate and it is your responsibility to ensure accuracy. Not all services are covered by your insurance plan. **Estimated co-pays and patient portions are due at the time of service.** Checks returned for non-sufficient funds will be charged a \$25 service fee and must be cleared with guaranteed funds. We provide financing with Care Credit approval with two options, 6 months or 12 months at 0% APR. Care Credit is a third party finance company and their interest rates are subject to change. Please refer to the Care Credit application process for more detailed information. Balances over 120 days without payment will be turned over to collections at a 28% fee. **We require a 24-hour cancellation notice.** The following discounts and incentives are offered for self-pay and non- covered services only.

- 5% Courtesy discount - Payment in full at time of service via Cash, Check only. Cannot be used with any form of credit card payment or insurance co-pays.
- Service Members 5% Courtesy discount - Applicable for members of the armed services, fire department, police department and teachers.
- Senior Citizen 5% Courtesy Discount— Applicable for patients 65 and older.
- **Discounts cannot be combined.**

I have read the office financial policy and agree to the conditions as stated above.

Signature: _____ **Date:** _____