Alpenglow Dental

Patient's Legal Name:_____ Preferred First Name:_____

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

Phone – Primary:_____ Secondary:_____ Work:_____

Social Security #:_____ Birthdate:_____ Sex: M ____ F____

Marital Status: Single____ Married____ Child____ Email Address: _____

How did you find out about our practice: Friend or Relative (name)_____
Telephone Book:____ Online Yellow Pages:____ Mailer:____ Internet Search Engine:____ Drive By:____ Other____

RESPONSIBLE PARTY INFORMATION – (if different then above)

Legal Name:_____ Preferred First Name:_____

Relationship to Patient:_____

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

Phone – Primary:_____ Secondary:_____ Work:_____

Social Security #:_____ Birthdate:_____ Sex: M ____ F____

Marital Status: Single____ Married____ Email Address: _____

PRIMARY INSURANCE

Insured's Name:_____ Social Security #:_____ Birthdate:_____

Patient's Relationship to Insured: Self:____ Spouse:____ Child:____ Other:____

Employer:_____ Phone #:_____ Union Local:_____

Insurance Company:_____ Group # :_____

Claims address:_____

SECONDARY INSURANCE

Insured's Name:_____ Social Security #:_____ Birthdate:_____

Patient's Relationship to Insured: Self:____ Spouse:____ Child:____ Other:____

Employer:_____ Phone #:_____ Union Local:_____

Insurance Company:_____ Group # :_____

Claims address:

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- How long ago did you last see a dentist? _____ Are you now in pain? ☐ Yes ☐ No If yes, please explain:_____

_____

- Do you consider yourself to be in good health? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, name of physician:_____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain:_____

_____

- Are you taking any medications, including birth control pills? ☐ Yes ☐ No If yes, please list:_____

_____

- Are you allergic to latex, anesthetics or medications? ☐ Yes ☐ No If yes please list:_____
- Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? ☐ Yes ☐ No If yes, please list:_____
- Do you require or have you been advised to be premediacted with antibiotics prior to dental treatment? If yes, please explain:_____

_____

I hereby certify that to the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my medical condition or in medications I take, I will inform the doctors and staff at the next appointment without fail.

_____ Date: _____

(Signature of patient, legal guardian or authorized agent of patient)

Consent to Proceed: I authorize the doctors and/or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. Including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments that could possibly be used.

I understand that the administration of local anesthetic may cause an untold reaction of side effects, which may include, but are not limited to; bruising, hematoma, cardiac stimulation, temporary numbness and rarely, permanent numbness and muscle soreness. I do voluntarily assume any and all possible risks associated with general preventative, operative and surgical procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand the doctor and staff will discuss the risks, benefits and alternatives prior to treatment. I acknowledge that I can request the doctor or staff for written procedure specific consents that will detail the risks prior to any procedure being performed.

HIPPA: I acknowledge that I have had the opportunity to review a copy of the HIPPA laws.

Dental Insurance: Determination of insurance payment made by this office are estimates only. I understand dental insurance is a contract between patient/guardian and the insurance company and in no way absolves the patient/guardian from full responsibly of charges incurred.

Finance Charges: Any balance over 30 days past due is considered delinquent and is subject to collection processing. Any delinquent balances will result in me being charged Alpenglow Dentals full fees or contracted insurance fees. I agree to pay any and all costs in collecting all balances, including a collection fee of 35% of balance, attorney fees and court costs.

Appointments: In the unlikely event that you are unable to make your appointment we ask that you give us 48 hours notice. I understand there will be a charge of $1 per minute for any appointment missed or broken without 24 hours notice.

Signature _____ **Date** _____

FOR OFFICE USE ONLY

Insurance Benefits

Effective Date _____ Annual Maximum Benefit _____ Used _____

Individual Deductible _____ Family Deductable _____ Deductable met YES NO

_____% Diagnostic / Preventive

_____% Basic

_____% Major Oral Surgery Periodontics Endodontics
(circle above if part of major)

Pay crowns on seat/ prep

YES NO Missing Tooth Clause
YES NO Cleaning 6 mo + 1 day _____
YES NO Dental Implants

YES NO Fluoride / age limit_____
YES NO Sealants / age limit_____
YES NO Limited Exams Covered

YES NO Orthodontic coverage / amount _____ / age limit _____
YES NO Waiting periods _____ # of months
YES NO Downgrade composites and crowns

Last Pano_____, Last FMX_____