CHUGACH
— Dental, LLC —
Adam Jensen, DDS

Patient Information

Full Name: ____Date: ____________________
(First Name) (Middle Initial) (Last Name)

Preferred Name ______________________________DOB: _____________SSN: ______________

Male: ☐ Female: ☐ Preferred Pronoun: ______ Marital Status: ________ Cell #: ____________ Work #: __________

Employer: _____________________________Occupation: ______________________________

Home Address: _________________________City: ______________State: ____ Zip Code: _______

Email: __________________________________How did you hear about us? __________________

Emergency Contact Name: _________________ Contact Number: _____________ Relationship: ________

Primary Dental Insurance Information

Insurance Co.: ____________________Group/Policy #: ______________Identification #: ______________

Policy Holders Name: ________________________________SSN: ___________ DOB: ___________
(First Name) (Middle Initial) (Last Name)

Relationship to Patient: ________________ Male: ☐ Female: ☐ Marital Status: _______ Contact #: ______________

Employer: ______________________ Home Address: ___________________________________

City: ____________________________State: ___________________ Zip Code: ___________

Secondary Dental Insurance Information

Insurance Co.: ____________________Group/Policy #: ______________Identification #: ______________

Policy Holders Name: ________________________________SSN: ___________ DOB: ___________
(First Name) (Middle Initial) (Last Name)

Relationship to Patient: ________________Male: ☐ Female: ☐ Marital Status: _______ Contact #: ______________

Employer: ______________________ Home Address: ___________________________________

City: ____________________________State: ___________________ Zip Code: ___________

Office Communication

May we email you? Yes ☐ No ☐ May we text you? Yes ☐ No ☐

Preferred method of contact? Phone ☐ Text ☐ Email ☐

May we leave a detailed voice message regarding your account and or treatment? Yes ☐ No ☐

Is there anyone else we may share your information with? Yes ☐ _______________________ No ☐
(name)

DENTAL & HEALTH HISTORY

Previous Dentist: _______________ Last Dental Exam: ____________ Date of last dental treatment (i.e. fillings, crowns): _________________

I routinely see my dentist every: 3 mo.☐ 4 mo.☐ 6 mo.☐ 12 mo.☐ Not routinely ☐ Main dental concern? ____________________________

Dental Fear/Anxiety _________________________ Yes ☐ No ☐
Previous Dental Complications _______________ Yes ☐ No ☐
Have you had any teeth removed? Including wisdom teeth removal _______________________ Yes ☐ No ☐
Diagnosed with gum disease or bone loss? ______ Yes ☐ No ☐
Gum Recession _____________________________ Yes ☐ No ☐
Cavities within the last 3 years _______________ Yes ☐ No ☐
Hot and or cold sensitivity ____________________ Yes ☐ No ☐
Clench or Grind teeth _______________________ Yes ☐ No ☐
Ever bleached/whitened your teeth ___________ Yes ☐ No ☐
Unfavorable dental experience ________________ Yes ☐ No ☐

Previous braces or orthodontic treatment ______________ Yes ☐ No ☐
Pain or Bleeding while brushing or flossing _____________ Yes ☐ No ☐
Experience loosening teeth/difficulty biting into an apple _ Yes ☐ No ☐
Unpleasant taste or odor in your mouth ________________ Yes ☐ No ☐
Feel or notice holes in your teeth ______________________ Yes ☐ No ☐
Pain in jaw or jaw joints ____________________________ Yes ☐ No ☐
Wear a nightguard or a biting appliance_______________ Yes ☐ No ☐
Ever been unhappy with the feel/appearance of previous dental work ______________________________ Yes ☐ No ☐
Would you like fluoride treatments? ___________________ Yes ☐ No ☐
May your children receive fluoride treatments? __________ Yes ☐ No ☐

Medications

1) _______________________ 4) ___________________________
2) _______________________ 5) ___________________________
3) _______________________ 6) ___________________________

Allergies

1) _______________________ 4) ___________________________
2) _______________________ 5) ___________________________
3) _______________________ 6) ___________________________

Primary Physician: ______________________ Phone #: _________________ Pharmacy & Location: __________________________________

Actively being treated for any other illness _________________ Yes ☐ No ☐
Alcohol Drinks per day: _____ Per Week: _________________ Yes ☐ No ☐
Anemia or other blood disorder ___________________________ Yes ☐ No ☐
Are you in good health __________________________________ Yes ☐ No ☐
Are you taking a blood thinner, ex: Wardarin, Coumadin, Aspirin, Plavix, Xarelto, or Brilinta _________________________ Yes ☐ No ☐
Arthritis ____ Yes ☐ No ☐
Artificial heart valve _____________________________________ Yes ☐ No ☐
Asthma ____ Yes ☐ No ☐
Bisphosphonates, ex: Fosamax, Actonel, Boniva, Reclast ____ Yes ☐ No ☐
Bleed or bruise easily ____________________________________ Yes ☐ No ☐
Breathing or sleep problems (Sleep apnea, snoring) _________ Yes ☐ No ☐
Cancer, if so what type: __________________________________ Yes ☐ No ☐
Cardiac stent, pace maker, or defibrillator __________________ Yes ☐ No ☐
Chemotherapy, immunosuppressive medication _____________ Yes ☐ No ☐
Depression Diagnosed, when: ______________________________ Yes ☐ No ☐
Diabetes, Type: ____ Yes ☐ No ☐
Premed required prior to dental treatment __________________ Yes ☐ No ☐
Emphysema/ shortness of breath __________________________ Yes ☐ No ☐
Fainting spells/dizziness _________________________________ Yes ☐ No ☐
FEMALE- Birth control ___________________________________ Yes ☐ No ☐
FEMALE- Pregnant or possibly pregnant ___________________ Yes ☐ No ☐
Frequent headaches _____________________________________ Yes ☐ No ☐
Hay fever/ Sinus Problems_______________________________ Yes ☐ No ☐

Heart Disease ____________________________ Yes ☐ No ☐
Heart murmur ____________________________ Yes ☐ No ☐
Hepatitis, Type: ___________________________ Yes ☐ No ☐
Herpes _________________________________ Yes ☐ No ☐
High Cholesterol __________________________ Yes ☐ No ☐
High or low blood pressure __________________ Yes ☐ No ☐
History of infective endocarditis _____________ Yes ☐ No ☐
History or prolonged bleeding _______________ Yes ☐ No ☐
HIV / AIDS ______________________________ Yes ☐ No ☐
Hospitalized for illness or injury _____________ Yes ☐ No ☐
Joint Replacement, if so when: ______________ Yes ☐ No ☐
Kidney Disease ___________________________ Yes ☐ No ☐
Liver Disease ____________________________ Yes ☐ No ☐
Lumps or swelling in mouth _________________ Yes ☐ No ☐
Previous head injuries _____________________ Yes ☐ No ☐
Psychiatric treatment ______________________ Yes ☐ No ☐
Radiation Therapy, when: ___________________ Yes ☐ No ☐
Rheumatic or Scarlet fever __________________ Yes ☐ No ☐
Rheumatoid Arthritis _______________________ Yes ☐ No ☐
Seizures, when: __________________________ Yes ☐ No ☐
Smoke/Chew tobacco? _____________________ Yes ☐ No ☐
Stomach Ulcers ___________________________ Yes ☐ No ☐
Stroke, when? ____________________________ Yes ☐ No ☐
Thyroid Disease ___________________________ Yes ☐ No ☐

Patient Signature: ____________________________________ Date: ________________
Doctor Signature: ____________________________________ Date: ________________

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HIPPA PRIVACY POLICY

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Chugach Dental. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations. This Notice of Privacy Practices also describes my rights and the responsibilities and duties to the office with respect to my protected health information. Chugach Dental reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. If you would like to see or obtain a copy of our full Privacy Practice Notice, please ask the front desk for a full copy.

I authorize Chugach Dental to share my information with the individual(s) listed below:

FINANCIAL GUIDELINES

As a courtesy, our team will gladly submit insurance claims on your behalf. We ask that you provide us with the most current dental insurance information and update us as often as changes occur. In addition, we ask that you review your plan and understand the details of coverage including: plan limitations, frequencies, waiting periods and maximums. Please also inform us if you have used benefits at another dental office within your plan year. We are happy to provide insurance and patient portion estimates to you. It is your responsibility to contact your insurance company if no payment has been made on a claim after 30 days from the date of submission**. Regardless of insurance payment or non-payment, any balance incurred will ultimately be your responsibility.**

I understand that payment is due at the time services are rendered. We have a variety of payment options including: 5% Cash or Check discount if amounts are paid in full at the time of service; All Major Credit Cards such as: Visa, Master Card, and AMEX; and Care Credit.
I understand that my account may be forwarded to collects if the balance is over 90 days old. Account balances over than 90 days are subjected to a 12% interest charge.

By signing this form, I acknowledge that I have read and agree to the above information. I understand that I am financially responsible for payment of any treatment provided, regardless of insurance payment or non-payment. I agree to keep my account balance in good standing by closing all balances greater than 45 days past any and all dates of service.

GENERAL CONSENT

I authorize Chugach Dental to provide treatment based on my oral health care needs. I agree to communicate any changes to my medical condition(s) at each visit. I understand that I will be informed of any treatment that my provider feels is pertinent to my oral health. By signing this form, I am allowing the providers of Chugach Dental to give me an oral examination that best suits my dental concerns during my visit. I also consent to allowing the providers at Chugach Dental to perform the necessary x-rays that are required in order for the providers to properly diagnose and clear me of any and or all dental treatment. Lastly, I consent to the providers of Chugach Dental to perform a general cleaning, otherwise called a prophylaxis, on me as my provider deems necessary.

Patient Name Printed ______________________________________

Patient/Guardian Signature __________________________________ Date______________

Doctor Signature ____ Date______________