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 ☐

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HIPAA 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_____

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APPOINTMENT POLICY AND AGREEMENT

Our goal is to provide quality dental care in a timely manner. In order to do so, we have implemented a cancellation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is also in need of treatment. We ask that you **contact our office at least two business days (48 hours) in advance to cancel or reschedule your appointment**.

NO SHOW POLICY

A "no-show" is an appointment that was not canceled in advance (minimum of 24 hours in advance). No shows are inconsiderate of other patients who also need dental care.

A no-show for a reserved appointment will result in a $50 fee that must be paid prior to reserving future appointments.

LATE ARRIVALS

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 10 minutes late to your reserved appointment, you may be asked to reschedule.

Thank you for choosing Chugach Dental for your dental care needs. We look forward to a long lasting relationship with you.

ACKNOWLEDGEMENT

My signature below indicates that I have read, understand and agree to the appointment policy above.

Patient Name (Printed) _____
Patient/Guardian (Signature) _____
Date _____