



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 <input type="checkbox"/> No <input type="checkbox"/>	Previous braces or orthodontic treatment _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Previous Dental Complications _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain or Bleeding while brushing or flossing _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had any teeth removed? Including wisdom teeth removal _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Experience loosening teeth/difficulty biting into an apple _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosed with gum disease or bone loss? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Unpleasant taste or odor in your mouth _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Gum Recession _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Feel or notice holes in your teeth _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Cavities within the last 3 years _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain in jaw or jaw joints _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Hot and or cold sensitivity _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Wear a nightguard or a biting appliance _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Clench or Grind teeth _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Ever been unhappy with the feel/appearance of previous dental work _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Ever bleached/whitened your teeth _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Would you like fluoride treatments? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Unfavorable dental experience _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	May your children receive fluoride treatments? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol Drinks per day: _____ Per Week: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart murmur _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia or other blood disorder _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis, Type: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you in good health _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you taking a blood thinner, ex: Wardarin, Coumadin, Aspirin, Plavix, Xarelto, or Brilinta _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	High Cholesterol _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	High or low blood pressure _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial heart valve _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	History of infective endocarditis _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	History or prolonged bleeding _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Bisphosphonates, ex: Fosamax, Actonel, Boniva, Reclast _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV / AIDS _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleed or bruise easily _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospitalized for illness or injury _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Breathing or sleep problems (Sleep apnea, snoring) _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Replacement, if so when: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer, if so what type: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Cardiac stent, pace maker, or defibrillator _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy, immunosuppressive medication _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Lumps or swelling in mouth _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Depression Diagnosed, when: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous head injuries _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes, Type: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric treatment _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Premed required prior to dental treatment _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Therapy, when: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema/ shortness of breath _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic or Scarlet fever _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting spells/dizziness _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatoid Arthritis _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
FEMALE- Birth control _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures, when: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
FEMALE- Pregnant or possibly pregnant _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoke/Chew tobacco? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Frequent headaches _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Ulcers _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay fever/ Sinus Problems _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke, when? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
	Thyroid Disease _____ Yes <input type="checkbox"/> No <input type="checkbox"/>



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. **Please note: A convenience Fee of 3% will be added to credit card transactions to cover processing costs. This fee does not apply to cash or debit card payments.**

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 _____



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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 _____