CHUGACH
— Dental, LLC —
Adam Jensen, DDS

Responsible Party

(Person who brought patient to appointment and Signed Office Policy)

____

Relationship to Child

____

Child's Full Name _________________________

Preferred Name _________________ □ **Male** □ **Female**

Birthdate _____/_____/_______

Phone Number (   ) _______________

Mailing Address

____

City _________________ **State** _____ **Zip code** __________

Mother's Name _________________________

Birthdate _____/______/ ___________

Social Security Number ____________________

Cell Phone (______) _______________

Alt Phone (______) _______________

Mailing Address _________________________

City/ State/ Zip _________________________

Employer _________________________

Email Address _________________________

Father's Name _________________________

Birthdate _____/______/ ___________

Social Security Number ____________________

Cell Phone (______) _______________

Alt Phone (______) _______________

Mailing Address _________________________

City/ State/ Zip _________________________

Employer _________________________

Email Address _________________________

With whom does this child reside?

PRIMARY DENTAL INSURANCE

Employee _____________________ Relation to child ___________ Insured DOB __________
Employer ______________________________ Insurance Co. ___________________________
ID# _______________________ Group# __________________ Phone# __________________

SECONDARY DENTAL INSURANCE

Employee ____________________ Relation to child ___________ Insured DOB __________
Employer ___________________________ Insurance Co. _______________________
ID# _______________________ Group# __________________ Phone# __________________

I hereby authorize payment directly to Chugach Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Chugach Dental to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____________________________ **Date** _____________

DENTAL HISTORY

Question		
Is this your child's first dental visit?	**YES**	**NO**
Previous Dentist's Name? _______________________		
Last visit? _______________________		
Does your child feel nervous about having dental treatment?	**YES**	**NO**
Has your child ever had a bad dental experience?	**YES**	**NO**
Has your child been seen by an orthodontist?	**YES**	**NO**
Have there been any injuries to your child's teeth or jaws?	**YES**	**NO**
Has your child ever been premedicated for dental work?	**YES**	**NO**
Would you like your child to receive fluoride treatments?	**YES**	**NO**

HEALTH HISTORY

Question		
Is your child having any pain or discomfort at this time?	**YES**	**NO**
Has your child been hospitalized during the past 2 years?	**YES**	**NO**
Has your child been under the care of a medical doctor during the past 2 years?	**YES**	**NO**
Is your child currently taking any medication?	**YES**	**NO**

List: ____

Please list any serious medical condition(s) that your child has or has had:

____

____

Please circle all that apply to your child:

Fingernail Biting

Lip or Cheek Biting

Grinding Teeth

Thumb or Finger Sucking

Jaw Difficulty: Clicking and/or Pain

Is your child allergic to or reacted adversely to any of the following?

Antibiotics — Latex

Codeine — Aspirin

Metals or Jewelry

Tree Nuts

Does your child have any allergies to any other medications, foods, or substances? If yes, please list:

Please circle "Yes or No" to the following conditions:

Condition			Condition			Condition		
Anemia	**YES**	**NO**	Hearing Impaired	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Asthma	**YES**	**NO**	Fever Blisters	**YES**	**NO**	Other?	**YES**	**NO**
Autism	**YES**	**NO**	Heart Murmur	**YES**	**NO**			
Chemotherapy or Cancer	**YES**	**NO**	Hepatitis, Type? ________	**YES**	**NO**			
Congenital Heart Defect	**YES**	**NO**						
Diabetes	**YES**	**NO**	HIV or AIDS	**YES**	**NO**			
Epilepsy	**YES**	**NO**	Tonsillitis	**YES**	**NO**			

Pediatrician/Physician	**Business Phone**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office or any changes in my child's medical status. I authorize the dentists and/or staff at Chugach Dental to perform the necessary dental services my child may need.

Parent/Guardian Signature ____ **Date** ________________________

MEDICAL HISTORY UPDATE (FOR OFFICAL USE ONLY)

☐ NO CHANGES	☐ NO CHANGES	☐ NO CHANGES
Parent signature	Parent signature	Parent signature
Date	Date	Date

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______________

Doctor Signature ____ Date______________

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 _______________