ALPINE DENTAL

MEDICAL ALERT

PATIENT INFORMATION
(PLEASE PRINT)

(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

Street City State Zip

Home Phone Work Phone Cell Phone Email Address
May we contact you by email? Y/N

Patient Date of Birth Patient Social Security Number Sex (M/F)

Emergency Contact **Phone**

How did you hear about us?
(Please be as specific as possible)

INSURANCE INFORMATION

Do you have **Dental** Insurance? ( ) Yes ( ) No
Do you have **Secondary Dental** Insurance? ( ) Yes ( ) No

PRIMARY INSURED

Subscriber Name:
Subscriber SSN:
Date of Birth:
Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Other ( )
Employer Name:
Employer Phone #:
Insurance Company:
Insurance Group #:

SECONDARY INSURED

Subscriber Name:
Subscriber SSN:
Date of Birth:
Relationship to Subscriber: ( ) Self ( ) Spouse ( ) Other
Employer Name:
Employer Phone #:
Insurance Company:
Insurance Group #:

please present card to receptionist to be photocopied

HIPAA Disclosure
Signed Acknowledgement of Notice of Privacy Practices.

Date

ADMINISTRATIVE INFORMATION

DENTAL HEALTH INFORMATION - CONFIDENTIAL

Although dentists primarily treat the area in and around the mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is confidential.

Patient's Name: _____ Date of Birth _____

Last Physical Date: _____ Physician's Name & Phone #: _____

Reason for today's visit? _____ ***Work Related Injury? Yes No***

Have you been under the care of a physician? _____ Date of last dental visit: _____

Have you ever been hospitalized? _____ Date of last dental x-rays: _____

Ever had Novocain or other local anesthetic? _____ If wearing dentures, age of dentures: _____

Are you taking Aspirin or any other anticoagulant therapy of any kind? _____

If playing sports, do you need a mouth guard? _____

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? _____

Have you had an adverse reaction to or become ill from penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? YES NO

List any medications you are allergic to:

1.	2.
3.	4.

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1.	2.
3.	4.

Do you have a history of:	YES	NO		YES	NO		YES	NO
Rheumatic Fever	( )	( )	Venereal Disease	( )	( )	Sinus Problems	( )	( )
Heart Murmur	( )	( )	HIV Positive/Aids	( )	( )	Cancer (Type:)	( )	( )
Mitral Valve Prolapse	( )	( )	Blood Transfusion	( )	( )	Chemotherapy	( )	( )
Heart Problem(	( )	( )	Excessive Bleeding	( )	( )	Radiation Treatment	( )	( )
Pace Maker/Heart Surgery	( )	( )	Anemia	( )	( )	Use of Tobacco Products	( )	( )
'High Blood Pressure	( )	( )	Hepatitis (Type)	( )	( )	Drug Addiction	( )	( )
Low Blood Pressure	( )	( )	Liver Disease	( )	( )	Alcoholism	( )	( )
Diabetes	( )	( )	Kidney Disease	( )	( )	Psychiatric Treatment	( )	( )
Stroke	( )	( )	Dialysis	( )	( )	Mouth sores/growths	( )	( )
Lung Disease	( )	( )	Thyroid Disease	( )	( )	Teeth Grinding/Clenching	( )	( )
Breathing Problems	( )	( )	Epilepsy or Seizures	( )	( )	Pain in your jaw (TMJ)	( )	( )
Tuberculosis (TB)	( )	( )	Fainting or Dizzy Spells	( )	( )	Any type of Implant	( )	( )
Asthma	( )	( )	Ulcers or Stomach Problems	( )	( )	Any type of Transplant	( )	( )
Allergies or Hives	( )	( )	Arthritis	( )	( )	Any Artificial Hip, Knee or other Joint		

Other Disease or Illness: _____

WOMEN	YES	NO
Is there a possibility of pregnancy?	( )	( )
Estimated Delivery Date_____	( )	( )
Are you nursing?	( )	( )
Are you taking any birth control prescriptions?	( )	( )

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature Date Dr's Signature/Medical History Review Date

Patient's Signature Date Dr's Signature/Medical History Review Date

HEALTH HISTORY

ALPINE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, AUTHORIZATION TO RELEASE INFORMATION, AUTHORIZATION OF PAYMENT OF BENEFITS, AND CONSENT FOR TREATMENT.

I have received a copy of Alpine Dental's Notice of Privacy Practice of effective January 2, 2006

I hereby authorize Alpine Dental to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize payment directly to Alpine Dental. I agree that a photocopy of this authorization is as valid as the original.

Signature _____ Date _____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

PAYMENT AGREEMENT
I understand and agree that payment is due at the time services are rendered and that health, dental and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of insurance. In the event my account balance is referred to any agency or attorneys for, collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees for professional services rendered will be immediately due and payable.

Signature _____ Date _____
(if patient is a minor, Parent or Guardian must sign here and complete section below)

RESPONSIBLE PARTY

(Dr/Mr/Mrs/Ms/Miss)	First	Middle	Last	Jr/Sr
SSN	DOB			M / F Sex
Street		City	State	Zip
( ) Home Phone	( ) Work Phone		Employer	

METHOD OF PAYMENT *How will you pay for today's visit?*

☐ Cash ☐ Bank Check ☐ *Care Credit ☐ *Unicorn ☐ Charge Card ☐ Other _____ ☐ Free Consultation

***See Receptionist for Application Forms**

CHARGE CARD AUTHORIZATION

By signing hereunder, I hereby authorize Alpine Dental to bill my charge card account should any balance for services rendered remain outstanding. If the account information given expires or is otherwise discontinued, I agree to give Alpine Dental information as to an alternate charge account, which may be used. My account is as follows:

☐Visa ☐ MasterCard ☐ Discover ☐ American Express Card # _____ Exp Date _____

Signature _____ Date _____

CONSENT FOR TREATMENT

I request the performance of the procedure(s) that are warranted given the nature of my condition. I am aware that there are general and unexpected risks arid complications may occur and that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

Signature _____ Date _____

TREATMENT PLAN RELEASE