WOODSIDE DENTAL GROUP
2900 Boniface Parkway,
Anchorage, AK, USA
(907) 333-1211

Patient Information

Basic Information

Patient First Name

Patient Middle Initial

Patient Last Name

Patient Preferred Name

Patient Birth Date

Patient Gender

- ◯ Male
- ◯ Female
- ◯ Decline
- ◯ Other

More Info

Patient SSN

Referral

Patient Picture

Office Use Only
Please attach

Patient Driver's License

Office Use Only
Please attach

Contact Information

Employer

Cell Phone

Home Phone

Work Phone

Ok to send text reminders?

- ◯ Yes
- ◯ No

Email

Ok to send email reminders?

- ◯ Yes
- ◯ No

Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Emergency Contact

Relationship to patient

Emergency Contact Phone

Responsible Party Information

Are you the responsible party on your account?

- ◯ Yes
- ◯ No

Relationship to patient

Guardian First Name

Guardian Middle Initial

Guardian Last Name

Guardian Preferred Name

Guardian Birth Date

Employer

Cell Phone

Home Phone

Work Phone

Ok to send text reminders?

- ◯ Yes
- ◯ No

Email

Ok to send email reminders?

- ◯ Yes
- ◯ No

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Medical History

Medical History

Patient First Name

Patient Last Name

Patient Birth Date

Are you under the care of a physician?

◯ Yes ◯ No

Please add your physician name and contact information here

Have you ever been hospitalized or had a major operation?

◯ Yes ◯ No

Please add more details here

Have you ever had a serious head or neck injury?

◯ Yes ◯ No

Please add any details here

Do you take, or have you taken, Phen-Fen or Redux?

○ Yes ○ No

Please add any details here

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

Please add any details here

Are you on a special diet?

○ Yes ○ No

Please add any details here

Do you use tobacco?

○ Yes ○ No

Please add any details here

Do you use controlled substances?

○ Yes ○ No

Please add any details here

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your denta appointment?

○ Yes ○ No

Please add any details here

Do you take any blood thinners?

- ◯ Yes
- ◯ No

Please add any details here

Have you ever had endocarditis?

- ◯ Yes
- ◯ No

Please add any details here

Were you born with a congenital heart defect?

- ◯ Yes
- ◯ No

Please add any details here

Do you have an artificial heart valve?

- ◯ Yes
- ◯ No

Please add any details here

Are you allergic to Penicillin?

- ◯ Yes
- ◯ No

Please add any details here

Do you have any artificial joints?

- ◯ Yes
- ◯ No

Please add any details here

Are you pregnant or trying to get pregnant?

- ◯ Yes
- ◯ No

Are you nursing?

- ◯ Yes
- ◯ No

Are you taking oral contraceptives?

- ◯ Yes
- ◯ No

Do you have any allergies?

Allergies

- ☐ Animals
- ☐ Barbiturates or sedatives
- ☐ Codeine or other narcotics
- ☐ Food
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin or other antibiotics
- ☐ Seasonal
- ☐ Sulfa drugs
- ☐ Other

Please add any details here

Do you have any medical conditions? We need this information to keep you healthy and safe

Digestive or Dietary Conditions

- ☐ Acid reflux/persistent heartburn
- ☐ Eating disorder
- ☐ Excessive urination
- ☐ Gastrointestinal disease
- ☐ Malnutrition
- ☐ Severe or rapid weight loss
- ☐ Special diet

Autoimmune Conditions

- [ ] Ankylosing spondylitis
- [ ] Celiac disease
- [ ] HIV or AIDS
- [ ] Immune deficiency
- [ ] Lupus
- [ ] Multiple sclerosis
- [ ] Rheumatoid arthritis

Neurological Conditions

- [ ] Autism
- [ ] Brain aneurysm
- [ ] Brain injury
- [ ] Epilepsy
- [ ] Fainting
- [ ] Migraines/severe headaches
- [ ] Seizures
- [ ] Stroke

Lung or Breathing Conditions

- [ ] Asthma
- [ ] Bronchitis
- [ ] COPD
- [ ] Cystic Fibrosis
- [ ] Emphysema
- [ ] Tuberculosis

Heart or Circulatory Conditions

- [ ] Angina
- [ ] Arteriosclerosis
- [ ] Artificial heart valve
- [ ] Cardiovascular disease
- [ ] Congenital Heart Disease (CHD)
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart transplant
- [ ] High blood pressure
- [ ] Infective endocarditis
- [ ] Low blood pressure
- [ ] Mitral valve prolapse
- [ ] Pacemaker
- [ ] Pulmonary embolism
- [ ] Rheumatic heart disease

General Diseases

- [ ] Anemia
- [ ] Bleeding disorder/Hemophilia
- [ ] Cancer
- [ ] Diabetes
- [ ] Glaucoma
- [ ] Hepatitis
- [ ] Jaundice or Liver disease
- [ ] Osteoporosis
- [ ] Renal/Kidney problems
- [ ] Sexually transmitted disease
- [ ] Sleep Apnea
- [ ] Total joint replacement
- [ ] Other

Please add any details here

Do you take any medications?

Pain Medications

- [ ] Aspirin
- [ ] Codeine
- [ ] Demerol (Meperidine)
- [ ] Hydrocodone (Vicodin/Lortan/Norco)
- [ ] Ibuprofen
- [ ] Percocet (Oxycodone)
- [ ] Ultram (Tramadol)

Antibiotics

- [ ] Amoxicillin
- [ ] Ciprofloxacin
- [ ] Clindamycin
- [ ] Doxycycline
- [ ] Tetracycline
- [ ] Zithromax (Azithromycin)

Antidepressant and Anxiety

- [ ] Adderall
- [ ] Ambien (Zolpidem)
- [ ] Celexa (Citalopram)
- [ ] Cymbalta (Duloxetine)
- [ ] Effexor (Venlafaxine)
- [ ] Lexapro (Escitalopram)
- [ ] Neurontin (Gabapentin)

Allergy or Asthma

- [ ] Claritin (Loratadine)
- [ ] Flonase (Fluticasone)
- [ ] Singulair (Montelukast)
- [ ] Ventolin (Albuterol Inhaler)
- [ ] Zyrtec (Cetirizine)

Diabetes, Cholesterol, or Blood Pressure

- [ ] Avapro (Irbesartan)
- [ ] Coreg (Carvedilol)
- [ ] Coumadin (Warfarin)
- [ ] Crestor (Rosuvastatin)
- [ ] Klor-Con (Potassium Chloride)
- [ ] Lasix (Furosemide)
- [ ] Lipitor (Atorvastatin Calcium)
- [ ] Lopressor (Metoprolol)
- [ ] Losartan (Cozaar)
- [ ] Metformin (Glucophage)
- [ ] Microzide (Hydrochlorothiazide)
- [ ] Norvasc (Amlodipine)
- [ ] Plavix (Clopidogrel)
- [ ] Pravachol (Pravastatin)
- [ ] Prinivil (Lisinopril)
- [ ] Tenormin (Atenolol)
- [ ] Toprol XL (Metoprolol)
- [ ] Tricor (Fenofibrate)
- [ ] Zestoretic (Lisinopril)
- [ ] Zocor (Simvastatin)

General Medications

- [ ] Aclasta/Reclast (Zoledronic Acid)
- [ ] Boniva (Ibandronate)
- [ ] Cialis (Tadalafil)
- [ ] Cyclobenzaprine (Flexeril)
- [ ] Didronel (Etidronate)
- [ ] Fosamax (Alendronate)
- [ ] Medrol (Methylprednisolone)
- [ ] Meloxicam (Mobic)
- [ ] Pantoprazole (Protonix)
- [ ] Prednisone
- [ ] Prilosec (Omeprazole)
- [ ] Synthroid (Levothyroxine)
- [ ] Other

Please add any details here

Have you ever had any serious illness not listed above?

- ◯ Yes
- ◯ No

Please add any details here

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

- [ ] I agree the above information is correct to the best of knowledge

Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name

Relationship

Address

Date signed:

Legal Guardian's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

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Dental History

Dental History

Patient First Name

Patient Middle Initial

Patient Last Name

Patient Birth Date

Reason for your scheduled appointment? You can choose more than one.

- [ ] Just a regular exam
- [ ] Pain
- [ ] Cleaning
- [ ] Second Opinion
- [ ] Cosmetic Consult
- [ ] Other

More Info

Previous Dentist

Why are you changing your dentist?

When was your last dental exam?

When did you have your last dental cleaning?

Personal History

How often do you brush?

- ◯ Every time I eat
- ◯ Three times a day
- ◯ Twice a day
- ◯ Once a day
- ◯ Occasionally
- ◯ Sometimes
- ◯ Never

How often do you floss?

- ◯ Every time I eat
- ◯ Three times a day
- ◯ Twice a day
- ◯ Once a day
- ◯ Occasionally
- ◯ Sometimes
- ◯ Never

Does going to the dentist make you nervous?

- ◯ No
- ◯ Yes, slightly
- ◯ Yes, moderately
- ◯ Yes, extremely

Have you ever had a bad experience at the dentist?

○ Yes ○ No

Please add any details here

Have you ever had complications from past dental treatment?

○ Yes ○ No

Please add any details here

Have you ever had trouble getting numb or had any reactions to local anesthetic?

○ Yes ○ No

Please add any details here

Periodontal / Gum disease

Do your gums bleed sometimes or are they ever painful when brushing or flossing?

○ Yes ○ No

Please add any details here

Have you ever been treated for gum disease or been told you have lost bone around your teeth?

○ Yes ○ No

Please add any details here

Is there anyone with a history of gum / periodontal disease in your family?

○ Yes ○ No

Please add any details here

Have you ever experienced or been told by a previous dentist that you have gum recession, or can you see more of the roots of your teeth?

◯ Yes ◯ No

Please add any details here

Have you ever had any teeth become loose without an external injury, or do you have difficulty biting into harder fruits and vegetables?

◯ Yes ◯ No

Please add any details here

Dental Problems

Are you teeth sensitive to hot, cold, sweet foods or liquids? Do you avoid brushing a part of your mouth because of sensitive teeth?

◯ Yes ◯ No

Please add any details here

Do you feel that your mouth is too dry or had difficulty swallowing food?

◯ Yes ◯ No

Please add any details here

Do you frequently get food caught between any teeth?

◯ Yes ◯ No

Please add any details here

Are you aware of sores or irritated areas in the mouth?

- ◯ Yes
- ◯ No

Please add any details here

Do you grind your teeth? Have you been told by a partner or a previous dentist that you grind your teeth?

- ◯ Yes
- ◯ No

Please add any details here

Improvements

Is there something you would like to change about your smile?

- ☐ The color of my teeth
- ☐ Close spaces or restore worn out / broken teeth
- ☐ Change the shape of my teeth
- ☐ Make my teeth straighter
- ☐ Replace missing teeth
- ☐ Nothing, I like my smile
- ☐ Other

More Info

I would be interested in learning more about the following topics

- [ ] Teeth whitening
- [ ] Cosmetic evaluation
- [ ] Replacement of missing teeth
- [ ] Straight teeth
- [ ] Sedation
- [ ] White fillings
- [ ] Home care
- [ ] Breath control
- [ ] Nothing
- [ ] Other

More Info

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Dental Insurance Form

Primary Insurance

Do you have dental insurance

- ◯ Yes
- ◯ No

Dental insurance card front

Office Use Only
Please attach

Dental insurance card back

Office Use Only
Please attach

Patient's relationship to the policy holder

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other

More Info

Policy Holder's First Name

Policy Holder's Last Name

Policy Holder's Birth Date

Policy Holder's Employer

Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Insurance Company

Subscriber ID

Group Number

Phone number on the back of your insurance card

Address on the back of your insurance card

Secondary Insurance

Do you have secondary dental insurance?

- ◯ Yes
- ◯ No

Dental insurance card front

Office Use Only
Please attach

Dental insurance card back

Office Use Only
Please attach

Patient's relationship to the policy holder

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other

More Info

Policy Holder's First Name

Policy Holder's Last Name

Policy Holder's Birth Date

Policy Holder's Employer

Address

Address 1

Address 2

City

State / Province

Zip Code / Postal Code

Insurance Company

Subscriber ID

Group Number

Phone number on the back of your insurance card

Address on the back of your insurance card

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Office Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$75.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$75.00** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

Patient First Name

Patient Last Name

Patient Birth Date

I have received this policy and agree with its contents.

Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name

Relationship

Address

Date signed:

Legal Guardian's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

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Financial Policy

Office Financial Policy

I understand that my dentist and staff will estimate insurance as close as possible. I understand that I am responsible for the payment of the account and providing correct insurance information.

I understand that if insurance is not applicable when dental services are rendered; my full payment is due at the time of service.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. Treatment goes over my maximum benefits.

B. Insurance benefits have been utilized elsewhere.

C. I am not eligible for insurance when services are rendered.

D. I prevent or delay the payment by not complying with requests for insurance forms or signatures.

E. I do not complete my treatment and it results in non-payment by the insurance company.

F. Lab costs are incurred due to missing appointments.

G. Lab modifications.

H. I receive my insurance check and do not send it to your office.

I have read and understand my obligations in acceptance of my dental insurance as payment.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

Patient First Name

Patient Last Name

Patient Birth Date

☐ I have received this policy and agree with its contents.

Signature

Signature By Patient

Date signed:

Patient's Signature

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Signature By Guardian

Name

Relationship

Address

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Legal Guardian's Signature

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Hipaa Informed Consent

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

Treatment Services: We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.

Payment and Health Care Operations: We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.

Marketing/Fundraising: We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.

Legal Requirements: We may use or disclose your health information when required to do so by law.

Abuse or Neglect: If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.

National Security: When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.

Family Members, Friends, and Others Involved in Care: At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

Business Associates: Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Research: We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.

Public Health Activities: We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability: to report reactions with medications or problems with products, to notify people of recalls of products they may be using to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition, to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).

Other Authorizations: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Breach Notification: We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certai other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we wil abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the HHS.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

Patient First Name

Patient Last Name

Patient Birth Date

☐ I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment and health care operation purposes.

Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

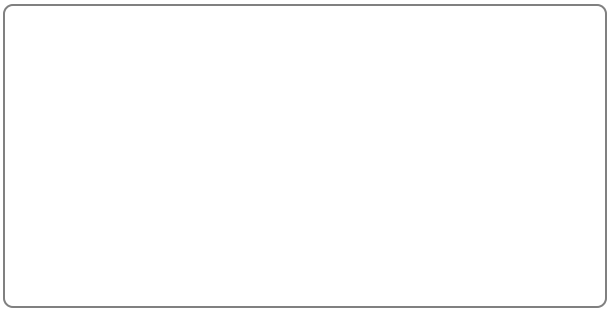
Name

Relationship

Address

Date signed:

Legal Guardian's Signature



By drawing in the box above I understand and agree that this is a legal representation of my signature