Mat Su Dental Center

Personal Information

Name _____

Date _____ Birthdate _____ SSN _____

Prefered Name _____

Male/Female

Mailing Address _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____ referred by _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Primary Insurance	
Name of insured	
Relation to insured	
Date of Birth of insured	
Subscriber ID/SSN	
Employer	
Insurance company	
Group Number	
Secondary Insurance	
Name of insured:	
Date of Birth of insured	
Relation to insured	
Subscriber ID/SSN	
Employer	
Insurance company	
Group Number	

Responsible Party

Name_____ Relation to Patient_____

Birthdate,_____ Driver's License #_____

SSN,_____Phone_____

Address,_____

City _____State _____ Zip Code _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

_____

Signature of patient or guardian Date

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____

Birth date _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check any that apply)

- ☐ Cancer or tumor
- ☐ Heart ailment or Angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hayfever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma

Do you smoke or use chewing tobacco?

❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics ("Novocain")
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other: _____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: _____

_____

Women:

pregnant

Expected delivery date: _____

Taking hormones or contraceptives

PreMed

Do your require Antibiotic Pre Med before dental treatment?

❑ yes ❑ no

Name of your physician _____

Do you have any disease, condition, or problem not listed above? _____

_____

Please add anything else you would like us to know about: _____

_____

Signature of patient (or parent) _____ Date _____

951 E. BOGARD RD. STE #203
WASILLA, AK 99654
PH.NO. 907-376-2456
FAX.NO. 907-376-2458

APPOINTMENT POLICY

Once an appointment has been made, that time is reserved for you. Because this is the reserved time, a late arrival of fifteen minutes or more will require rescheduling your appointment. We also require a 24-hour notice if you need to cancel or reschedule an appointment, so another patient may utilize that time. There will be a charge of $25.00 for no-shows or cancellation under 24 hours.

New Patients who fail to show for their appointments will be dismissed from our offices. Established patients who have a total of three last minute cancellation (i.e. those with less than 24hour notice) and/or failures to show for and appointment will also be dismissed as a patient from our office. While we do occasionally make Saturday appointments (when a doctor is available), these are considered “Privileged Appointments.” Because of this, a failed Saturday appointment will not be rescheduled to another Saturday.

We will make appointments for multiple family members to be seen on the same day, as a courtesy. However, if any member of the family cancels for any reason without giving us a 24-hour notice, we will no longer schedule Multiple family members together on the same day.

Please let us know if you have any questions or concerns.

I, undersigned (parent or legally responsible), have read and agree to above Appointment Policy

Signature: _____ Date: _____

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Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:
1. Cash
2. Check
3. MasterCard
4. Visa
5. Discover
6. Care Credit

Patient with insurance: Mat Su Dental files insurance claims on behalf of our patient's as a courtesy. It is the patient's responsibility to know the provisions and limitations of their policy. The patient is responsible for the **ESTIMATED** non-covered portion, procedures and/or deductibles at the time of the service. **If the insurance company does not pay after 60 days, we will bill you directly for the full balance.**

Accounts that are more than 120 days past due will be referred to Cornerstone Collection Services.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

There is a $45.00 processing charge for **non-sufficient funds** or returned checks.

MEDICAID RECIPIENTS: Should you start any prosthetic treatment (crowns, bridges, partials, ect.) and not return for completion, or if you are determined ineligible at completion, according to the Alaska Medicaid System, you will personally be held liable FOR THE ENTIRE BALANCE.

I, _____, agree to these financial terms.

Signature _____ Date _____

ACKNOWLEDGEMENJ OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request.

Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: _____

Parent/Legal Guardian Name: _____

Signature:_____Date:_____

Relationship to Patient: _____

For office use ,only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

Other (please specify)_____