PATIENT INFORMATION

Patient Name ______________________________ Date of Birth ____________

Parent/Guardian if Minor ______________________________ Home phone ____________

Spouse if Married ______________________________ Date of Birth ____________

Current Address ______________________________ City ____________

State ______________________________ Zip ____________

Mailing Address ______________________________ City ____________

State ______________________________ Zip ____________

Alaska Driver's License # ____________________ Social Security # ____________________

Cellular Phone ____________________ E-mail Address ____________________

Previous Address if less than 2 years at above ______________________________

City ____________ State ____________ Zip ____________

Referred by: ______________________________

Place of employment ______________________________ Position ____________

Length of employment ______________________________ Telephone ____________

Employment address ____________________ City ____________ State ____________

Spouse's place of employment ______________________________ Position ____________

Length of employment ______________________________ Telephone ____________

Name of nearest relative not residing with you ______________________________

Current address & phone number ______________________________

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DENTAL INSURANCE INFORMATION

Name of insurance company ______________________________ Group Number ____________

Current address & phone number ______________________________ Subscriber ID# ____________

Relationship to insured ______________________________ Insured date of Birth ____________

If you have a second dental insurance, please fill in the following:

Name of insurance company ______________________________ Group Number ____________

Name of insured person ______________________________ Subscriber ID# ____________

Local # ______________________________ Insured date of birth ____________

* **PLEASE COMPLETE BACK OF FORM** *

MEDICAL HISTORY

	Question		
1.	Are you having pain or discomfort at this time? ______	YES	NO
2.	Do you feel very nervous about having dental treatment? ______	YES	NO
3.	Have you ever had a bad experience in the dental office? ______	YES	NO
4.	Have you been a patient in the hospital during the past two years? ______	YES	NO
5.	Have you been under the care of a medical doctor during the past two years? ______	YES	NO
6.a	Have you taken any medicine or drugs during the past two years?	YES	NO
6.b	List current medications.______		
7.	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ______	YES	NO
8.	Have you ever had any excessive bleeding requiring special treatment? ______	YES	NO
9.	Circle any of the following which you have had or have at present: ______	YES	NO

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Hepatitis C
Heart Murmur	Hay Fever	Liver Disease
Rheumatic Fever	Sinus Trouble	Yellow Jaundice
Congenital Heart Lesions	Allergies or Hives	Blood Transfusion
Scarlet Fever	Diabetes	Drug Addiction
Artificial Heart Valve	Thyroid Disease	Hemophilia
Heart Pacemaker	X-Ray or Cobalt Treatment	Venereal Disease (Syphilis, Gonorrhea)
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Cold Sores
Artificial Joint	Arthritis	Genital Herpes
Anemia	Rheumatism	Epilepsy or Seizures
Stroke	Cortisone Medicine	Fainting or Dizzy Spells
Kidney Trouble	Glaucoma	Nervousness
Ulcers	Pain in Jaw Joints	Psychiatric Treatment
Bruise Easily	HIV Positive	Sickle Cell Disease

	Question		
10.	When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ______	YES	NO
11.	Do your ankles swell during the day? ______	YES	NO
12.	Do you use more than two pillows to sleep? ______	YES	NO
13.	Have you lost or gained more than 10 pounds in the past year? ______	YES	NO
14.	Do you ever wake up from sleep short of breath? ______	YES	NO
15.	Are you on a special diet? ______	YES	NO
16.	Has your medical doctor ever said you have a cancer or tumor? ______	YES	NO
17.	Do you have any disease, condition, or problem not listed? ______	YES	NO
18.	WOMEN: Are you pregnant now? ______	YES	NO
	Are you practicing birth control? ______	YES	NO
	Do you anticipate becoming pregnant? ______	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

______ Date

______ Signature of Patient, Parent or Guardian

Stephen M. Maloney, D.M.D.
Family Dentistry
1113 W. Fireweed Lane. Anchorage, AK. 99503 (907) 279-6000

OFFICE POLICY AND FINANCIAL AGREEMENT

Dr. Maloney and staff would like to welcome you to our practice. We thank you for the opportunity to meet your dental needs. Our goal is to provide you with the very best in dental treatment. In order for you to become acquainted with our office, we are providing you with this statement of our financial policies. Please feel free to consult us about any questions you may have.

INSURANCE ASSIGNMENTS

As a courtesy to you, the office staff will complete the dental portion of your insurance claim form at no charge. We will file your claim for you provided the patient information portion is completely filled out and signed by the appropriate parties. Please also supply the address and phone number of your insurance company; otherwise, payment in full is expected at the time of service. Deductibles and estimated co-payments are due when treatment is rendered. Any overpayment will be refunded to you after the insurance payment has been received. Claims not paid by your insurance company by the 61st day after treatment will be billed to you. Please remember that the financial obligation for dental treatment is between you and this office. However, we will gladly assist you in resolving any problems concerning insurance queries, lost claims, and processing follow-ups, etc.

MISSED APPOINTMENTS

Every effort will be made to confirm your appointment on the business day before you are scheduled. However, it is important that you understand that this time has been reserved specifically for you. No charge will be made for rescheduling appointments when 24-hour notice is given; otherwise, a charge of $100.00 per half-hour missed appointment will be incurred. After 3 missed appointments, services may be discontinued.

SERVICE CHARGES

An accounting and rebilling charge of $12.00 per month and interest at 10.5% APR will be applied to all accounts after 60 days, regardless of insurance involvement. Returned checks will incur a charge of $30.00.

COLLECTION FEES

Fees incurred to enforce payment required by this agreement will be paid by the delinquent client.

FINANCIAL CONSENT

The patient (guardian) agrees to be fully responsible for the total payment of procedures performed in this office, including any treatment not a benefit of any dental insurance the patient may have. I certify that I have read, understood, and agreed to this. I have received a copy of this financial agreement. I will pay for today's treatment by: check__ cash__ credit card__

Patient's signature____ Date__________________

Parent/Guardian if patient is a minor)

Witness____ Date__________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002