SunMountain Dental Care

Todd Christensen DDS
Smiles@SunMountainDental.com
907.357.5757

Patient Information

Name _____ Soc Sec # _____

Mailing address _____

City _____ State _____ Zip _____

Physical address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient employed by _____

Occupation _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Mobile Phone _____ Business Phone _____

Email _____

Primary Insurance *If we will be able to scan your insurance card during your visit, you can skip this part*

Person responsible for account _____

Relation to patient _____ Birthdate _____ Soc Sec # _____

Person responsible employed by _____

Insurance company _____

Patient ID # _____ Group # _____

Is there a secondary insurance? ☐ Yes ☐ No *If yes, see the front desk*

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former dentist _____

Dentist's city and state _____

Dentist's phone _____

Date of last dental care _____ Last X-rays _____

How often do you brush? _____ Floss? _____

How do you feel with the appearance of your teeth? _____

Other information about your dental health or previous treatment:

_____

_____

Check yes or no for the following:

Bad breath.....	☐Y ☐N
Bleeding gums.....	☐Y ☐N
Clicking or popping jaw.....	☐Y ☐N
Food collection between teeth..	☐Y ☐N
Grinding or clenching teeth.....	☐Y ☐N
Loose/broken teeth.....	☐Y ☐N
Periodontal treatment.....	☐Y ☐N
Sensitivity to cold.....	☐Y ☐N
Sensitivity to hot.....	☐Y ☐N
Sensitivity to sweets.....	☐Y ☐N
Sensitivity when biting.....	☐Y ☐N
Sores or growths in mouth.....	☐Y ☐N

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Medical History

Physician's name_____

Phone_____ Date of last visit _____

Have you had any serious illness or operations?..... ☐Y ☐N

If yes, describe:

Are you currently under physician care?..... ☐Y ☐N

If yes, describe:

Have you ever had a blood transfusion?..... ☐Y ☐N

If yes, give approximate dates:

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva. ☐Y ☐N

Women Are you pregnant?..... ☐Y ☐N

Nursing?..... ☐Y ☐N

Taking birth control pills?... ☐Y ☐N

List all medications the patient currently taking:_____

_____

_____

List all the patient's drug allergies _____

_____

List all patient's other allergies_____

_____

Authorization

I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Check yes or no for the following:

AIDS/HIV	☐Y	☐N
Anaphylaxis	☐Y	☐N
Anemia	☐Y	☐N
Arthritis, Rheumatism	☐Y	☐N
Artificial joints	☐Y	☐N
Asthma	☐Y	☐N
Back problems	☐Y	☐N
Blood disease	☐Y	☐N
Cancer	☐Y	☐N
Chemical dependency	☐Y	☐N
Chemotherapy	☐Y	☐N
Cough, persistent	☐Y	☐N
Diabetes	☐Y	☐N
Epilepsy	☐Y	☐N
Fainting	☐Y	☐N
Heart murmur	☐Y	☐N
Heart problems	☐Y	☐N
If yes, describe:		
Hemophilia/Abnormal bleeding	☐Y	☐N
Herpes	☐Y	☐N
Hepatitis	☐Y	☐N
High blood pressure	☐Y	☐N
Jaw pain	☐Y	☐N
Kidney disease or malfunction	☐Y	☐N
Liver disease	☐Y	☐N
Material allergies (latex, wool,	☐Y	☐N
chemicals.)	☐Y	☐N
Nervous problems	☐Y	☐N
Radiation treatment	☐Y	☐N
Respiratory disease	☐Y	☐N
Rheumatic/Scarlet fever	☐Y	☐N
Shortness of breath	☐Y	☐N
Stroke	☐Y	☐N
Surgical implant	☐Y	☐N
Thyroid disease or malfunction	☐Y	☐N
Tobacco habit	☐Y	☐N
Tuberculosis	☐Y	☐N
Ulcer/Colitis	☐Y	☐N
Cold Sores	☐Y	☐N

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Consent For Services

My relationship to the patient is:

☐ Self ☐ Parent
☐ Spouse ☐ Legal guardian(s)
☐ Adult child ☐ Other

I authorize the dental staff to provide dental services for

_____

(Print name of the patient)

Dental services are defined as oral hygiene cleaning, instruction, application of medicaments, fillings, periodontal treatment and surgery, nitrous oxide analgesia, extractions, oral surgery, root canal therapy, bridges and dentures, orthodontics, x-rays, other procedures deemed appropriate, and the consultation of the patient's physician if necessary. I agree to the use of the anesthetics and other medication as necessary. I fully understand that using anesthetic agents carry certain risks. I understand that I can ask for complete review of any possible complications.

Protecting Your Privacy

I am 18 years old or older. I authorize the dental staff to discuss the patient's dental treatment with the following people unless/until I withdraw this authorization in writing. Check all that apply and provide name(s).

☐ Parent(s) ☐ Legal guardian(s)
☐ Spouse ☐ Other

I authorize the dental staff the dental staff to call and leave messages regarding any pre-medication information for dental treatment. I acknowledge the patient has access to and accepts Sun Mountain Dental Care's Notice of Privacy Practices.

☐ This consent is indefinite
☐ This consent expires on _____

_____

Signature Date

Your Appointment Times

Appointments are reserved exclusively for you. If you are running late or need to cancel an appointment, please contact us as soon as possible if you arrive more than 5 minutes late for an appointment, we may need to reschedule. Our fee for same day cancellations is $50. To avoid cancellation fee, notify us at least 24 hours in advance. Initial _____

Insurance

Sun Mountain Dental Care is a preferred provider for Premera Blue Cross Blue Shield, Cigna, MODA Health, Delta Dental, Aetna, MetLife, Connection Dental, United Concordia, Tricare, Medicaid, and Denali Kid Care. If you do not have on of these, we are not a participating/preferred provider for your insurance company. Other companies may consider Sun Mountain Dental Care an out-of-network provider and may return payment at a lower rate than expected.

If you provide us with your insurance information, we will submit claims for you. We are happy to supply x-rays and explanations at the insurance carrier's request. However, our relationship is with you, not your insurance company. Your insurance policy is a contract between you and your insurance carrier; coverage appeals are your responsibility.

Our practice is committed to providing the best treatment for our patients and we charge what is representative in our region. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Initial _____

Payment

At the time of service, you are responsible for your percentage plus any deductible not covered by your insurance company. We accept cash, check, MasterCard, Visa, Discover, and American Express. We also accept CareCredit and Landing Club.

Balances older than 30 days may be subject to a $5 per month late fee. Balances over 90 days may be forwarded to a collection agency. Patients whose accounts have been sent to collections will not receive further treatment at this clinic. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for account management assistance. Initial _____

Communication

I agree Sun Mountain Dental Care may communicate with me through phone calls, texts, emails, postcards and letters. I agree our third-party marketing services may communicate with you. Initial _____