Advanced Family Dentistry
Dr. Steve Christensen & Dr. Craig Lowrie
1401 S. Seward Meridian Parkway Suite E
Wasilla AK, 99654
907-357-5018

Date___________________

NAME (Last) ________________________ (First) ______________________________
Mailing address_________________________________City_______Zip___________
Email address____
Home Phone_____________________Business Phone________________Cell______
Date of Birth______/_______/ ______Please Circle M / F. Married Single Other
Social Security #_____________________Occupation___________________________
Employer______________________Interest /Hobbies___________________________
Other family members seen by us: ____
Last Dental Visit: ____
Spouse /Parent or Guardian___________________Phone number__________________
Dental Insurance Coverage (please circle) YES NO

Primary Insurance

Insurance Name____
Insurance Address____
Insurance Phone#____
Group/Plan/Local#____
Insured's Name (subscriber)______________________Relation____________________
Insured's Birthday_____________________________SS#______________________
Insured's Employer____
Employer'sAddress____

Secondary Insurance

Insurance Name____
Insurance Address____
Insurance Phone#____
Group/Plan/Local#____
Insured's Name (subscriber)______________________Relation____________________
Insured's Birthday__________________________SS#___________________________
Insured's Employer____
Employer'sAddress____

EMERGENCY CONTACT:

Name______________________Phone______________Relation_______________

MEDICAL HISTORY

Name____________________________Date _________________________

What is your general state of health? _____Good____Fair____Poor_____
Name/Address/Phone number of Physician__________________________
____
Have you been under a physician's care during the last two years?________
Have you been treated in a hospital in the past three years?______________
Have you had major surgery?____
If female: Are you Pregnant?__Nursing:__Are you taking birth control?____
Do you have or had any of the following?

_ Epilepsy or Seizures
_ Fainting or Dizziness
_Stroke
_Persistent Cough
_Emphysema/Bronchitis
_Tuberculosis/PPD+
_Asthma
_Sinus Problems
_Anemia/Sickle cell
_Hepatitis A,B,C
_Liver Disease
_Pneumonia
_Nervousness/ Anxious
_ Irregular Heart Beat
_ Bruise/ Bleed Easy
_ Heart Problems
_ Chest Pain/Angina
_ High Blood Pressure
_ Rheumatic Fever
_ Heart Murmur
_ Mitral Valve Prolapse
_ Congenital Heart Lesions
_ Heart Surgery
_ Artificial Heart Valves
_ Pacemaker
_ Fibromyalgia
_Kidney Problems
_Venereal disease
_Diabetes
_Thyroid Disease
_AIDS/HIV
_Arthritis
_Artificial Joints
_Cancer
_ Chemotherapy
_Radiation
_ Organ Trans
_ Tobacco Use
_ Dry Mouth

Do you require any pre-medication of antibiotics prior to ANY dental treatment______
Do you have any condition, disease, or problem not previously listed?______________
____
____

DRUG ALLERGIES:
Aspirin____ Erythromycin___ Tetracycline__
Codeine____ Latex___ Other____
Dental Anesthetics___Penicillin__

Please list all medications you are taking, including over the counter drugs and herbs:
____
____

DENTAL HISTORY

So that we may provide you with the best possible care, please complete this information form:

How long has it been since your last dental visit?________________________________

Do you have a history of:

Bleeding gums__ Missing teeth__
Broken/chipped fillings__ Periodontial/Gum disease__
Cavities__ Tender/Swollen gums__
Food traps__ Worn teeth__
Loose teeth__
Orthodontics___If so how long ago?_____How long Treatment?___________________

Do you have any of the following:

Fixed bridge__
Full Denture__
Implants___
Loose/Broken Fillings__
Removable partial__

If so, are you comfortable with your replacements?____________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my health status.

Signature__________________________________Date___________________________

Insurance Policy

Advanced Family Dentistry LLC realizes how important your dental benefits are. We ask that you carefully review your policy and /or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and or restrictions. Please be aware that your insurance may have a yearly allowance(maximum) and anything over that amount will be your responsibility. **It is your responsibility to provide us with any changes in your insurance coverage._______(initial) I understand the above.**

Financial Policy

We bill insurance as a courtesy to our patients, however it is your responsibility to understand your dental coverage and benefits. In order to provide you with the highest quality dental care on a sound basis, we provide our patients with ESTIMATES of fees. Patient, parent and/or guardian are responsible for the patient portion on the date of service. This is not your insurance company's responsibility. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service**.**

Financial options we provide at this time:
Cash or check on date of service
Major credit cards
Care Credit/and or Financial Institution payment plan

Appointment Commitment

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and /or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected.______(initial)

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have a qualified team ready to accommodate you during your reserved appointment time.

We require and appreciate a 24-hour notice to reschedule an appointment.

Signature____Date_________________