Name DOB Date

Medical History

What Is the Reason for your visit? _____
_____
_____

Do You Have Any Current Dental Concerns? _____
_____
_____

When Was Your Last Visit to the Dentist? _____

Name of MEDICAL Doctor: _____

When was your last check up with your MEDICAL doctor? _____

List All Medications You Are Currently Taking:

_____

_____

_____

Do you take or have you ever taken any of the following medications?

Bis-Phosphonate (Fosamax, Boniva, Actonel, etc..) (generally used for osteoporosis or cancer treatment): ☐ No ☐ Yes Name of medication: _____ When: _____

Blood Thinners: (Coumadin, Warfarin, etc..) : ☐No ☐Yes Name of medications: _____ When:_____

Please check all that you are allergic or intolerant too:

☐ Latex
☐ Dental anesthetic / Epinephrine
☐ Tylenol / Acetaminophen
☐ Ibuprofen / Advil / NSAIDS
☐ Narcotics / Codeine / Hydrocodone
☐ Clindamycin
☐ Penicillin / Amoxicillin
☐ Shellfish
☐ Dairy / Milk Protein
☐ Nuts
☐ No known allergies

Other:

Signature Printed Name Date

Name DOB Date

Do you have, or have you had, any of the following medical conditions?

☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Heart Valve Replacement
☐ Stroke
☐ Bleeding Problems
☐ Thyroid Disease
☐ Cancer Type: _____ When: _____ Treatment received:_____
☐ Liver Disease / Hepatitis
☐ HIV / AIDS
☐ Asthma
☐ Kidney Disease
☐ Mental Health Disorder
☐ Sinus Trouble
☐ Joint Replacement
☐ Ulcers
☐ Seizures / Epilespy

Other:

Do you currently use any of the following?

☐ Cigarettes, Vapes, or Tobacco Products
☐ Other Recreational Drugs
☐ Marijuana or CBD Products

Women Only (Please Check Any That Apply):

☐ Currently pregnant Due date:_____
☐ Trying to get pregnant or could possibly be pregnant
☐ Currently using birth control
☐ Breastfeeding

By signing this form, I am acknowledging that it is true and accurate to the best of my knowledge. I agree to inform Golden Heart Dental if any changes to my medical history arise.

Signature Printed Name Date

Name DOB Date

Informed Consent

We ask that you read and understand this form carefully before receivng any exams or treatment at Golden Heart Dental. Feel free to ask any questions you may have.

Before you give consent for any treatment or the administration of any medications, you should understand that, depending on the procedure, there are certain associated risks, including, but not limited to the following:

- X-RAYS: You agree to periodic radiographic and clinical examinations based on your caries risk. We utilize digital x-rays which will expose you to minimal levels of radiation. These x-rays will be taken only on an 'as needed' basis to reduce your total exposure to the radiation.
- MEDICATIONS AND INJECTIONS: Reactions to medications may result in redness, swelling, pain, itching, vomiting, and/or anaphylactic shock (a severe allergic reaction). Risks of local anesthesia may include bruising, and temporary or permanent tingling sensations or numbing. You will be informed beforehand if a medication that may cause drowsiness will be prescribed or administered for a procedure, and it is your responsibility to arrange for safe transport to and from the dental office. Females taking contraceptives understand that some antibiotics and medications may reduce the effect of birth control pills, which may result in unexpected pregnancy. With your permission, certain medicaments, such as topical fluoride, chlorhexidine, betadine, or oral medications such as ibuprofen or antibiotics may be administered during you visit. Any allergies, contraindications, or preference against the use of these and other such medicaments should be explicitly communicated to the doctor and/or office staff.
- CLEANINGS ("prophy" or "scaling and root planing"): Sensitivity of teeth and gums during or following a cleaning can occur. Please let us know if you have sensitive teeth so that we can attempt to make the appointment more comfortable. If you have been diagnosed with periodontal disease ("gum disease"), having a 'regular cleaning' performed will not be an option since it will not help treat the disease and can lead to further bone and even tooth loss.
- PICTURES: With your signature below, you authorize Golden Heart Dental to take radiographic images and live photos of your teeth, jaws, and face to be stored and used in your personal records. These photos and xrays may be used for communication with other healthcare professionals and third-party laboratories and vendors, all with your identifying information attached. Occasionally, we may use such photos, for educational publications, lectures, or informational and marketing purposes. We will make a concerted effort to hide any identifying information, such as your name, entire face, etc. By signing below, you consent to and release these photos for our use as indicated above and do not expect compensation, financial or otherwise
- COMMUNICATION (EMAILS, TEXTS, etc): You allow us to communicate with you or other medical professionals via unencrypted email, text, or other digital methods, the details of your treatment with your personal identifying information, including but not limited to, your medical history, dental history, pictures, planned treatment, completed treatment, etc. In these modern times, you understand and accept the possibility of a breach of information while communicating through such methods. You understand that while we make our best efforts to keep your information private and secure during these communications, we have no way to guarantee any mishandling of this information during transit or at their intended destination, which may lead to a breach of your private information.

Signature Printed Name Date

Name DOB Today's Date

Financial Agreement

We are grateful you have chosen Golden Heart Dental to provide care for your oral health. We are committed to providing you with the highest quality of dental care and don't want treatment cost to become an obstacle in achieving your oral health goals. We charge what is usual and customary for Fairbanks, Alaska and our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment.

It is our goal to help you maximize your insurance benefits and determine, to the best of our ability, your cost of treatment before you receive it so that you have no surprises. Ultimately, however, you are responsible for payment regardless of insurance companies' arbitrary determination of usual and customary rates. Your insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Your deductible and estimated co-payment will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage.

There may be times when treatment that is recommended by Golden Heart Dental may not be approved by your insurance. This can occur for various reasons such as frequency limitations (having treatment that was completed recently on the same tooth but now needs further treatment) or your insurance company may deny payment for treatment if they do not determine that it is necessary. By signing this form, I am agreeing to pay for these fees in full.

Please know that we will do everything possible to see that you receive the full benefits of your policy by filing your claim as soon as administratively possible. By signing this form, you are instructing your insurance company to make payments directly to our office. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Full payment for services is due at the time services are rendered. We accept payment in the form of checks and major credit cards. We also offer third party financing, such as Care Credit, which may provide deferred or no interest, and extended payments (approval and credit check required). Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. We would be happy to discuss our charges and how they relate to your situation. Please feel free to contact our wonderful staff at Golden Heart Dental any time to discuss any concerns you may have.

Rescheduling and Missed Appointments

Our practice is dedicated to quality care and exceptional service. Broken and missed appointments create scheduling problems for our team as well as other clients. But we also understand that sometimes life happens, so if you find that you must reschedule, we kindly ask for 48 hours advance notice so that we may utilize that time for another patient that may need it. If proper notice is not received, a fee of $50 will be charged. We REALLY don't like doing that, so please try to schedule accordingly. By signing this form, I agree to pay this fee if I miss an appointment.

Signature Printed name Date

Name DOB Date

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508(a))

I understand that as part of my healthcare, Golden Heart Dental originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

-a basis for planning my care and treatment

-a means of communication among the health professionals, medical and dental, who may contribute to my health care

- a source of information for applying my diagnosis and surgical information to my bill

- a means by which a third-party payer can verify the services billed were actually provided

- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

By signing this form, I am stating that I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I authorize the disclosure of my Protected Health Information as specified above for the purposes and to the parties designated by me.

Signature Printed Name Date