Advanced
FAMILY DENTISTRY

www.advancedfamilydentistryoffairbanks.com

Valued Guest,

Thank you for your call to our office. Our office is like no other dental office you have been to before.

> We use the latest technology and techniques offered in the field of dentistry. We will take special care and time to make sure you are comfortable with all aspects of your dental visit. We want to exceed all your expectations.

We have experience in many different aspects of dentistry including:

- Veneers
- Crowns (same-day for both metal and non-metal)
- Metal free fillings (do not contain silver mercury)
- Onlays (single visit crown alternatives)
- Root Canals (more comfortable and quicker procedure techniques)
- Extractions (extra training to make it comfortable for you)
- Dentures
- Whitening (how white do you want to go?)
- Smile Makeovers (see our before and afters)
- Implant Restorations

In addition we are continually learning new and advanced techniques in dentistry.

Please help complete the enclosed questionnaire so we can recommend a personalized dental plan based on your needs and wants. We will show you what the possibilities are and it is your decision what treatment you would like to have done. **Please return these to us two days prior to your appointment.** Fax (907) 374-6689. Email: mainoffice@alaskasmiles.com. Mail: 1005 Danby Street, Fairbanks, AK 99701.

Since you are an active participant in your dental treatment, we want to know what is important to you about your smile. We look forward to meeting you!

Sincerely,

Advanced Family Dentistry and Team

- 1005 Danby Street Fairbanks, Alaska 99701 P: (907)374-6688 F: (907)374-6689

Questionnaire

Your visit at our office will be the most thorough and detailed dental visit you have ever had. We will be using very and new innovative technology and taking special care to look at your overall oral health. We place high emphasis on helping you determine your present and future dental needs. Here are some of the things we will be discussing at your first visit. These may be questions you have never thought much about. Please circle what best expresses how you feel about the following questions.

- Are you having any areas of concern? (please describe)_____
  _____
- Tell us in your opinion the present state of health your mouth is:_____
  _____
- How healthy do you want your mouth to be?

  "Don't really care" Average The Best it can be
- Tell us about your good dental experiences…_____
  And the bad ones… _____
- What, if anything, would you like to change about your smile?_____
  _____
  _____
- What would it take for you to trust us?_____
  _____
- Do you have any family or friends that already come to our office?_____
- What do you already know about our office and what are your expectations?_____
  _____
- Have you seen our website @ www.advancedfamilydentistryoffairbanks.com?_____
- Has fear ever been an issue for you in a dental office?_____
- Has time ever been a factor in getting your dental work done?_____
- Has the cost of dental treatment been a concern for you?_____
  What can we do to help you with this?_____
- We have the unique ability to access your mouth from 3 different perspectives. What combinations of these would you like us to use for you? (please circle)

  as a **General** Dentist as a **Cosmetic** Dentist as a **Functional** Dentist
- At what point would you like to initiate treatment?

  When my tooth hurts or breaks When something is worsening When something isn't ideal
- What quality of dentistry would you like us to recommend?

  "Just patch it" Average Ideal/the Best

Is there any additional information you would like us to know?_____
_____
_____.

Dental History

Do you think you have Decay, Gum Disease or Jaw Problems?	Yes	No
Does your floss shred when you use it?	Yes	No
Do your gums ever bleed?	Yes	No
Does food pack or catch between your teeth?	Yes	No
Does your breath concern you?	Yes	No
Do you ever have clicking, popping or jaw discomfort?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you had braces?	Yes	No
Do you smoke or chew tobacco?	Yes	No
Do you Vape	Yes	No
Are you interested in improving your smile?	Yes	No
Would you like to have whiter teeth?	Yes	No

Medical History

SYMPTOMS

Headaches	Yes No	Sinus Problems	Yes No	Heart Murmur	Yes No
TMJ Pain	Yes No	Asthma	Yes No	Artificial Heart Valve	Yes No
TMJ Noise	Yes No	Snoring	Yes No	Artificial Joint	Yes No
Limited Opening	Yes No	Liver Disease	Yes No	Congenital Heart Disorder	Yes No
Ear Congestion	Yes No	Angina/Chest Pain	Yes No	Mitral Valve Prolapse	Yes No
Dizziness	Yes No	Heart Attack/ Failure	Yes No	Rheumatic Fever	Yes No
Ringing in the Ears	Yes No	Blood Disease- kind?	Yes No	Lung Disease	Yes No
Difficulty Swallowing	Yes No	Blood Pressure Problem	Yes No	Kidney Problems	Yes No
Difficulty Chewing	Yes No	Bleed Easily	Yes No	Heart Pacemaker	Yes No
Loose Teeth	Yes No	Diabeties	Yes No	Other Heart Conditions_____	Yes No
Clenching/Grinding	Yes No	Hepatitis A, B or C	Yes No	_____	
Bell's Palsy	Yes No	Thyroid Disease	Yes No		
Facial Pain	Yes No	Cold Sores	Yes No		
Tender Sensitive Teeth	Yes No	Fever Blisters	Yes No		
Neck Pain	Yes No	Cancer Kind_____	Yes No		
Postural Problems	Yes No				
Tingling in Fingers	Yes No				
Hot and Cold Sensitivity	Yes No				
Nervousness	Yes No				
Insomnia	Yes No				
Trigeminal Neuralgia	Yes No				
Back Pain	Yes No				

Are you under a physicials care? If so describe_____ Yes No
Physicians Name:_____ Phone #:_____
Have you had a serious accident or hospitalization? If so describe_____ Yes No
Are you taking any medications now- including but limited to asprin or vitamins Yes No
If so Please list the names and dosages _____

Do you have any allergies that you are aware of?_____ Yes No
Penicillin Codeine Latex Sulfa Metals Acrylic
Women: Are you pregnant or trying? Yes No Nursing? Yes No Contraceptives? _____
Do you see a Chiropracter?_____ Yes No
Normal Blood Pressure if known ___/_____.

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions to the best of my knowledge. I will notify the office of any changes to my health or medications.

Patient Signature Date

_____
Printed Name

Patient Information

Patient Name:_____ Date:_____
First Middle Initial Last

☐Male ☐Female ☐Married ☐Single ☐Child Other:_____ Birth Date:_____

Social Security #:_____ Drivers License #:_____ Best time to call:_____

Email: _____

Phone- Home:_____ Work:_____ ext:____ Cell:_____

Address:_____
Street City State Zip

Referral Information

How did you hear abour us? ☐ WWW ☐ TV ☐ Flier ☐ Location ☐ Other_____

☐ Friend/Family--Whom may we thank for referring you to our practice?_____

Spouse / Guardian

The Following is for: ☐ the patients spouse ☐ the person responsible for the account

Name:_____ Date:_____
First Middle Initial Last

☐Male ☐Female ☐Married ☐Single ☐Child Other:_____ Birth Date:_____

Social Security #:_____ Drivers License #:_____ Best time to call:_____

Email: _____

Phone- Home:_____ Work:_____ ext:____ Cell:_____

Address:_____
Street City State Zip

Employment Information

The following is for: ☐ the patient ☐ spouse ☐ the person responsible for the account

Employer Name:_____ Occupation:_____

Address of Work:_____
Street City State Zip

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
First Middle Initial Last

Patients relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other_____

Name of Insurance Company:_____

ID# of insured:_____ SS# of insured:_____ Group #:_____

Insured's Birth Date:_____

Employeer Name:_____

Address of Insured's Work:_____
Street City State Zip

Secondary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
First Middle Initial Last

Patients relationship to insured: ☐Self ☐ Spouse ☐ Child ☐ Other_____

Name of Insurance Company:_____

ID# of insured:_____ SS# of insured:_____ Group #:_____

Insured's Birth Date:_____

Employeer Name:_____

Address of Insured's Work:_____
Street City State Zip

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:
1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Pra contains information about how we will insure that your information remains private.
Please list all telephone numbers where we may contact you:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Acknowledgement of Notice of Privacy Practice
I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice. I further understand that the pr will offer me updated to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

Printed Name of Patient:_____

Signature of Patient/Parent/Guardian: _____ Date: _____

FOR OFFICE USE ONLY:
Patient refused to sign
Patient was unable to sign because:_____
Date: _____Signature:_____