Legends DENTAL
GEORGE JEDLICKA, DMD

Adult Information and Health History

Patient Name _____ Date of Birth _____
(Last) (MI) (First)

Nickname _____

Mailing Address _____ City _____ State _____ Zip _____

Drivers License # _____ Social Security # _____

Residence Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Spouse (Name) _____ Date of Birth _____

E-Mail Address_____**SS#** _____Cell Phone_____

Employer _____ Work Phone _____

Emergency Contact Person_____ Phone # _____
(Relationship)

Primary Dental Insurance

Insured Person _____ Date of Birth _____

Insurance Company _____ Group # _____ ID # _____

Secondary Dental Insurance

Insured Person _____ Date of Birth _____

Insurance Company _____ Group # _____ ID # _____

Consent for Dental Treatment

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that if I do not present both primary and any secondary insurances at the time services are rendered that I will be responsible for billing the secondary insurance. I hereby authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, including but not limited to collection agency fees of 35%, incurred by me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I certify 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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist/dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature_____ Date_____

_____

Patient Name_____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE <u>DON'T KNOW</u> ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address_____
2. Are you under a Physician's care?..... YES NO
3. When was your last complete physical exam?.....
4. Are taking any medication or substances?..... YES NO
   (If yes, please list medications in the "comments" box to the right)
5. Do you routinely take health related substances?..... YES NO
6. Are you allergic to any medications or substances?..... YES NO
7. Do you have any other allergies.....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?..... YES NO
9. Are you sensitive to any metals or latex?..... YES NO
10. Are you pregnant or suspect you may be?..... YES NO
11. Do you use any birth control medications?..... YES NO
12. Have you ever been treated for or been told you might have heart disease?YES NO
13. Do you have a pacemaker or artificial heart valve implant?..... YES NO
14. Have you ever had rheumatic fever?..... YES NO
15. Are you aware of any heart murmurs?..... YES NO
16. Do you have high or low blood pressure?..... YES NO
17. Have you ever had a serious illness or major surgery?..... YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES NO
20. Do you have any artificial joints / prosthesis?..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?..... YES NO
22. Have you ever bled excessively after being cut or injured?..... YES NO
23. Do you have any stomach problems?..... YES NO
24. Do you have any kidney problems?..... YES NO
25. Do you have any liver problems?..... YES NO
26. Are you diabetic?..... YES NO
27. Do you have asthma?.....YES NO
28. Do you have epilepsy or seizure disorders?..... YES NO
29. Do you or have you had a venereal disease?..... YES NO
30. Have you tested HIV positive?..... YES NO
31. Do you have AIDS?..... YES NO
32. Have you had or do you test positive for hepatitis?.....A B or C..... YES NO
33. Do you or have you had T.B?..... YES NO
34. Do you smoke, chew, use snuff or any other form of tobacco?..... YES NO
35. Do you consume alcoholic beverages?..... YES NO
36. Do you habitually use controlled substances?..... YES NO
37. Have you had psychiatric treatment?..... YES NO
38. Do you have any disease, condition, or problem not listed?..... YES NO
    If so, explain_____
39. Is there anything else we should know about your health that we have not covered in this form?_____

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN SIGNATURE_____DATE_____

44820 E PARKS HIGHWAY ◆ SOLDOTNA, ALASKA 99669 P: 907.260.4700 F: 907.260.4004 LEGENDSDENTALAK.COM

Legends DENTAL
JEROME JEDLICKA, DMD

APPOINTMENT POLICY

We see patients on an appointment basis. Your appointment time is reserved exclusively for you. We respect your time and will make every effort to remain on schedule; therefore we ask that you please arrive on time for your appointment.

We understand that circumstances arise that prevents patients from keeping appointments. If you are not able to keep an appointment, please give us a call 24 hours in advance. (exception may be made in an emergency). With this notice we can reschedule your appointment for the near future.

We request this courtesy as it allows us to see our patients promptly.

Our policy states that once the 2nd scheduled appointment is missed, a notice will be sent alerting of the consequence of missing the 3rd scheduled appointment within a 12 month period. That consequence is that the patient will be allowed emergency care only. This is defined as a probationary period and will be in effect for 12 months.

Appointment failure is defined as:

1. Any appointment for which the patient does not arrive and notify the clinic at least 24 hours in advance
2. A patient that arrives 15 minutes into the appointment

I have read and understand the above appointment policy for Legends Dental.

_____

4/2007