2525 Gambell Street #304A Anchorage, AK 99503
(907) 276-1621 (main) * (907) 279-0562 (fax)
www.erslanddentistry.com

PATIENT INFORMATION

Patient Name: ____ Birth Date:_________________________
Last First MI Preferred Name

☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child

Social Security #:____________________________ Driver's License #:____

Home Phone:______________________Work Phone:__________________Cell Phone:__________________________

Mailing Address: ____
Street City State Zip

Email: ____

Who may we thank for referring you?
☐ **Family/Friend name**:______________________ ☐ **Internet** (search words?)________________ ☐ Other______________

Responsible Party/Spouse/Parent Information

Patient Name: ____ Birth Date:_________________________
Last First MI

Social Security #:____________________________ Driver's License #:____

Home Phone:______________________Work Phone:__________________Cell Phone:__________________________

Email:____

Primary Insurance Information

Insurance Company: ______________________________
Ins. Phone #_________________________________
Subscriber: ___________________________________
Subscriber Birth Date:____________________________
SSN/ID#______________________________________

Secondary Insurance Information

Insurance Company: ______________________________
Ins. Phone #:_________________________________
Subscriber: ___________________________________
Subscriber Birth Date:____________________________
SSN/ID#______________________________________

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Glaucoma
☐ Growths
☐ Hay Fever

☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment

☐ Respiratory problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Sleep Apnea
☐ Snoring
☐ Stomach Problems
☐ Stroke
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcers

☐ Pregnant now?
Due Date_________

ALLERGIES:
☐ Aspirin
☐ Codeine
☐ Erythromycin
☐ Latex
☐ Penicillin
☐ Local Anesthetic
☐ Other___________
____
____

ERSLAND FAMILY DENTAL

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

Name of Physician: ______________________________ Phone: ____________________

Do you often feel tired, fatigued, or sleepy during the daytime? Yes No

Has anyone observed you stop breathing or snore loudly while you are sleeping? Yes No

Do you use or have you used a CPAP machine? Yes No

Please list all **medications** you are now taking: (we can copy a list if it is available) ______________________

____

DENTAL INFORMATION

Please share the following dates:

Your last cleaning ______________________

Your last oral cancer screening______________

Your last complete x-rays________________

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Where?____________________
- ☐ Headaches, neck or jaw joint pain
- ☐ Teeth or filings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces

Is keeping your teeth important to you? Y N

Do you smoke or use chewing tobacco?

- ☐ Y
- ☐ N

If yes, how much?__________for how long?_______

If you could change your smile, would you:

- ☐ Whiten your teeth?
- ☐ Straighten your teeth?
- ☐ Close spaces?
- ☐ Replace metal fillings with tooth colored fillings?
- ☐ Repair chipped teeth?
- ☐ Replace missing teeth?
- ☐ Replace old crowns that don't match?
- ☐ Have a smile makeover

On a scale of 1-10; 10 being highest

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____

What is the most important thing to you about your dental visit today?

____

Is there any other medical or dental Information you feel I should know about? ☐ Yes ☐ N

If Yes, Please Explain:____

I have reviewed the above information and give authorization to take x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of needs. I also give authorization to perform agreed treatment, medication and/or therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

I authorize the use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefit of my plan directly to this office.

X____Date:______________

Signature of patient, parent, or guardian

X____Date:______________

Doctor's Signature

Privacy Practices Acknowledgement and Receipt

You May Refuse to Sign this Acknowledgement

I, ____, have received a copy of Ryan P. Ersland, DMD, LLC Notice of Privacy Practices.

Patient Signature: ____Date: ____________________

☐ **REVOKE Consent**

If you check this box we still need your signature revoking consent.

I revoke my consent for your use and disclosure of my protected health information for treatment (i.e. referrals to specialists), payment activities (i.e. billing insurance), and healthcare operations.

Patient Signature: ____ Date: _____________________

Permission to release private health information

☐ **PLEASE Don't Share MY DENTAL Information**

If you check this box we do not need additional information, only your signature.

I give permission for the following people to have access to my private health and account information:

Name: __________________________________ Relationship: _______________________

Name: __________________________________ Relationship: _______________________

I give permission to employees and staff of Ryan P. Ersland, DMD, LLC to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission is optional and can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing Ryan P. Ersland, DMD, LLC Privacy Practices and shall remain in effect until revoked.

Patient Signature: ____Date: ________________

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

Our office would like to communicate with you electronically via email and/or text. By utilizing our practice's electronic services, you agree that Ryan P. Ersland, DMD, LLC may communicate with you regarding information about your invoice, accounts payable, insurance, dental treatment any dental visits. We do NOT give your email address to marketing companies.

I, ____, in the presence of my dentist or the dental practice's privacy representative, agree that the practice may electronically communicate with me at the previously given email address and/or cell phone.

PATIENT SIGNATURE: ____DATE: _______________

☐ **DECLINE SERVICE**

OFFICE AND FINANCIAL POLICIES

I have read and understand the Office and Financial Policies. I have had the opportunity to ask any questions and I agree to comply with the policies. I certify to the best of my knowledge that all information I have been provided is accurate and true. By signing this agreement, you agree to pay for any costs we estimate due to us prior to services being provided.

PATIENT SIGNATURE: ____DATE: ___________________