John P. Bast DDS, Inc
570 University Avenue
Fairbanks, Alaska 99709
(907) 479-2206

Welcome to our office! Please take a moment to complete this patient information form as thoroughly as possible. This information will help us to address your dental needs, concerns and desires.

PATIENT INFORMATION Date____________________

Name_____________________________ Physical Address_____________________________ How Long? ______

Home Phone_______________ Mailing Address____

Work Phone__________________ City__________________ State_________ Zip__________

Cell Phone ___________________ E-mail address ______________________________

Emergency Contact__________________________ Relationship________________ Phone Number_____________

Date of Birth____________ Social Security Number_____________ Driver's License Number_________________

Sex: M F Height__________ Weight__________ Marital Status___________________

Occupation_____________________ Employer_______________________________ How Long?______________

Spouse's Name____________________ Spouse's employer_________________________ How Long?___________

Insurance Company_______________ Subscriber's Name_______________ SSN_____________ Group No______

Secondary Ins. Co.______________ Subscriber's Name________________ SSN______________ Group No.______

Previous Dentist__________________ When was your last examination and cleaning? _________________

Whom may we thank for referring you? _________________________

Please check any of the following concerns that you have about your mouth:

_____Dental Pain	_____Dental Decay	_____Defective Fillings	_____Crowns/Bridgework
_____Tooth Wear/Abrasion	_____Tooth Sensitivity	_____ Bad Breath	_____Gum Recession
_____Tooth Fractures	_____Root Canal Therapies	_____ Bleeding Gums	_____Tooth Discoloration/Stain
_____Crooked/Crowded Teeth	_____Loose Teeth	_____Missing Teeth	_____Gum Discolorations/Lumps
_____ Biting Pain	_____ Hot Sensitivity	_____Cold sensitivity	_____Teeth Sensitive to Sugary Foods
_____Periodontitis/Gum Pockets	_____Wisdom Teeth	_____Teeth Pack Food	_____ Unsatisfied with Dentures
_____ TMJ noise or pain	_____Grinding/Clenching	_____Sleep Problems	_____ Headaches / Facial Pain

Please check any of the dental services that you are interested in:

_____Bleaching	_____Laminates	_____Straighter Teeth	_____Tooth Desensitization
_____Sealants	_____Nitrous / Sedation	_____Implants	_____Tooth Replacement
_____ Tooth Colored Fillings	_____Improved Esthetics	_____Nightguards	_____Athletic Mouthguard
_____Electric Toothbrush	_____Tobacco Cessation	_____Snoring Cessation	_____Dentures

Please check the description which best suits your desire from our office:

___ I want the best care available for my dental problems, allowing me to keep my teeth healthy for the rest of my life.

___ I only want the services requested.

Please rank the following in order of importance when reflecting on dental fillings (1 = most important):

_____Esthetics _____Longevity _____Cost

(OVER)

Medical History

Physician____________________________ Address______________________________________

Are you currently being treated for any medical problems? ______________________________

What medications are you taking? ____

What allergies do you have?____

Do you use tobacco? **Yes** **No** How much per day?__________ How many years?____________

Have you ever had a concussion or head injury? **Yes** **No** What sports do you play?____________

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

____ Anemia	____ Hepatitis / Jaundice / Liver Disease
____ Arthritis	____ High / Low Blood Pressure
____ Artificial Bones / Joints / Rods / Pins	____ HIV+/AIDS
____ Artificial or Damaged Heart Valves	____ Hospitalized for any reason
____ Asthma or Hay fever	____ Kidney Problems
____ Blood transfusions	____ Mastoid / Ear Infections
____ Cancer / Chemotherapy	____ Mitral Valve Prolapse
____ Cardiovascular disease	____ Nervous Problems
____ Congenital Heart Defects	____ Pregnant (Currently)
____ Diabetes	____ Psychiatric Problems
____ Drug / Alcohol Problems	____ Radiation Therapy
____ Emphysema / Difficulty Breathing	____ Rheumatic / Scarlet Fever
____ Epilepsy, Seizures, or Fainting Spells	____ Severe / Frequent Headaches / Migraines
____ Fever Blisters / Cold Sores / Herpes	____ Sinus Problems
____ Glaucoma	____ Stroke
____ Heart Attack	____ Thyroid problems
____ Heart Murmur	____ Tuberculosis
____ Heart Surgery / Pacemaker	____ Ulcers / Colitis
____ Hemophilia / Abnormal Bleeding	____ Venereal Disease

Have you had any disease, medical condition or problem not listed above? ______________________

_____________________________ _______________

Signature Date

Doctor Notes:

Date __________ BP / Pulse __________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

Date __________ BP / Pulse __________ MedHx Changes ______________________________

John P. Bast DDS

Welcome to the office of Dr. John P. Bast. We appreciate having you as a patient. This is a treatment consent form outlining our office procedures for your dental needs. Our office will provide professional treatment and the best available care for you. Please take a moment to read the following paragraph, and then sign below.

I authorize Dr. Fred Bast and his dental staff to take x-rays, diagnostic models, photographs and any other diagnostic aids to make a thorough diagnosis. I authorize Dr. Bast to perform treatment, medication, and therapy as necessary. I am fully responsible for all dental fees, which are payable at the time services are rendered. Should my account require finance charges or go to a collection agency, I agree to pay all the costs of collection and any finance charges.

Fee and Payment Policy: In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following as our financial policy. Our fees may be paid as follows:

______ **1.** Prepayment by cash or check before the day of treatment and receive a 5% discount for Check or Cash or 2.5% for Credit Cards. Prepayment saves us time and the expense of billing. If you have dental insurance, we will offer this payment adjustment for your portion of the fee that is not covered by insurance.

______ **2.** Third party patient financing company through Care-credit (CareCredit.com)

______ **3.** Payment of estimated portion not covered by insurance on day of service by cash, check or credit card. If no insurance will be filed by our office, your portion will be due at time of service.

Insurance: If you have dental insurance, we will help you determine the coverage you have available. We ask that you assign your insurance benefits to this office. The balance will be arranged for you to pay as listed above. Professional care is provided to you, our patient, and not to an insurance company. The insurance company is ultimately responsible to the patient, and the patient is responsible to the doctor. We will help in every way we can, in filing your insurance claim and handling insurance questions from our office on your behalf.

Cancellation Policy: If unable to keep an appointment, 24-48 hour notice is required or a cancellation fee of $100 per hour will be applied.

______________________________ ______________________

Signature **Date**

University Dental Center
John P. Bast, D.D.S., Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of University Dental Center's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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