Lara Mabry,DDS & Alexander DeYoung,DDS

2601 BONIFACE PARKWAY, SUITE 1
ANCHORAGE, ALASKA 99504
Telephone (907) 337-9448 Fax (907) 337-4123
mabrydentistry@gmail.com
www.mabrydentistry.com

PATIENT DEMOGRAPHIC

PLEASE PRINT

Patient's name _____ Nickname _____

DOB _____ Age _____ Parent/Caregiver name _____ home: _____

Patient's Employer: _____ work: _____

SS#: _____ How long employed? _____ cell: _____

Person responsible for this account? _____ Spouse name: _____

SS#: _____ Driver's license #/State _____

Residence address: _____ city/state/zip _____

Billing address: _____ city/state/zip _____

Where do you prefer your appointments to be confirmed? ☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Text ☐ Email _____ ☐ Any of the Above

Circle method of payment Cash Check Visa/MasterCard/Discover Grant Payee Service: _____

INSURANCE INFORMATION	**Primary Coverage**	**Secondary Coverage**	**Medical Coverage** (If applicable)
Name, address & phone # of insurance:			
Name of Subscriber:			
Group #/Date of birth/rank:			
Social Security #/Insurance ID #:			
Firm employed by			
Business Address:			
Business Phone/Duty Phone:			

Name and Phone # of nearest relative not living with you (in case of emergency) _____

Name and Phone # of your last dentist? _____

If necessary, can we request records? Y/N _____ Date of last x-ray? _____

Signature _____

What is your present dental problem? _____

Who may we thank for referring you to our practice? _____

MEDICAL HISTORY

Name of Family Doctor/Phone #: _____

Medical Diagnosis: (for surgery patients) _____

Possible surgery sedation? Y/N Why? _____

Are you under a physician's care now? Y/N If so, for what? _____

If you would like us to share account or treatment information with anyone, please list them below:

_____

_____

_____

_____

OFFICE POLICY FOR INSURANCE

As a courtesy to our patients, our office will bill insurance directly and collect the **estimated** co-payment and deductible at the time of service. If for any reason your insurance does not pay within 60 days, you are responsible for payment of the balance in full. A 1% per month (12% per year) finance charge is applied to your account once a balance carries over 60 days. Patients seen at surgery facilities may have an additional fee.

Signed: _____ Date: _____

Female patient: Are you pregnant? Y/N Doctors name: _____ How many months? _____

Are you subject to: nervous disorders ☐ fainting or dizziness ☐ grinding/clenching ☐ jaws pop/click ☐

Are you allergic to: penicillin ☐ latex ☐ metal ☐ novocaine/other anesthetics ☐ other allergies _____

Have you ever had the following?

☐ Stroke

☐ Heart Disease (specify)*

☐ Cardiac Pacemaker

☐ Heart Attack*

☐ Heart Murmur

☐ High Blood Pressure

☐ Rheumatic Fever

☐ Prolonged Bleeding

☐ Anemia

☐ Artificial Joints/Prosthetic Replacements (specify)*

☐ Recent Surgeries (specify)*

☐ Cancer

☐ Arthritis

☐ Thyroid Problems

☐ Diabetes

☐ Autoimmune Diseases (specify)*

☐ Kidney or Liver Disease

☐ Hepatitis (A, B or C)

☐ HIV Positive

☐ Asthma

☐ Tuberculosis

☐ Sinus Problems

☐ Glaucoma

☐ Epilepsy

☐ Cold Sores (Herpes)

☐ Chemical Dependency

☐ Other

* Please specify: _____

Medical history reviewed: _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____

Are you taking any medication? ☐ Yes ☐ No Please attach list with date _____

_____

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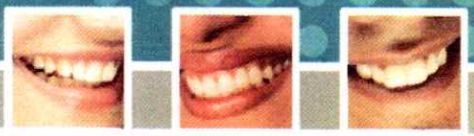

OFFICE POLICY

It is with the greatest pleasure that we welcome you to our dental practice. We are proud of staff, dedication to our patients and our goal is to provide you with optimal dental care.

If you currently have insurance, please present the appropriate information when checking in. WE BILL YOUR INSURANCE AS A COURTESY. YOUR ESTIMATED CO-PAYMENT WITH ANY DEDUCTIBLE IS DUE AT THE TIME YOUR TREATMENT IS PROVIDED. We do our best estimate your individual insurance. Please keep in mind each plan is different and other factors may apply. If your insurance does not pay your claim within 60 days, you are responsible for your balance. You will need to contact your insurance company regarding claims that are outstanding, we will provide you with any information that you may need to do so.

There is a $25.00 fee applied to all insufficient fund checks.

Due to liability, a parent or guardian must accompany children under the age of 18 to their appointments. If a minor requires assistance during treatment, we ask that only one guardian be present in the treatment area. No children are to be left unattended in the waiting area. Special Needs Patients need to be accompanied by a Guardian or Caretaker at every visit, no exceptions.

PLEASE NOTIFY OUR OFFICE 24 HOURS PRIOR TO RESCHEDULING OR CANCELLING AN APPPOINTMENT. MISSED OR BROKEN and LATE APPOINTMENTS WILL BE CHARGED **$50.00**. Insurance and Medicaid will not cover this fee. We reserve the right to dismiss patients for chronic missed or short notice rescheduled appointments. If you arrive 15 minutes late for your appointment you are subject to the **$50.00** late fee, and we will have to reschedule your appointment.

To facilitate being seen on time, we ask that new patients arrive 10 minutes prior to the appointment to fill out paperwork.

Thank you again for choosing our office for your dental needs.

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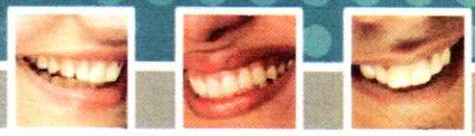

HIPAA ACKNOWLEDGEMENT

I understand that I have certain right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment) Obtaining payment from third party payers (e.g. my insurance company) The day to day healthcare operations have been informed and given the right to review and secure a copy of your NOTICE OF PRIVACY PRACTICES, which contains a more complete description of uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this content, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____