Mabry Dentistry, LLC & Associates
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ANCHORAGE, ALASKA 99504

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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:

____

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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	☐ Prolonged Bleeding	☐ Thyroid Problems	☐ Tuberculosis
☐ Heart Disease (specify)*	☐ Anemia	☐ Diabetes	☐ Sinus Problems
☐ Cardiac Pacemaker	☐ Artificial Joints/Prosthetic Replacements (specify)*	☐ Autoimmune Diseases (specify)*	☐ Glaucoma
☐ Heart Attack*	☐ Recent Surgeries (specify)*	☐ Kidney or Liver Disease	☐ Epilepsy
☐ Heart Murmur	☐ Cancer	☐ Hepatitis (A, B or C)	☐ Cold Sores (Herpes)
☐ High Blood Pressure	☐ Arthritis	☐ HIV Positive	☐ Chemical Dependency
☐ Rheumatic Fever		☐ Asthma	☐ Other

* Please specify: ____

Medical history reviewed: ________/_______/_______/_______/_______/______/______/ ______/ ______/ ______/ ______/______

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

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