LARA M. MABRY, DDS
ALEX DEYOUNG, DDS
2601 BONIFACE PARKWAY
ANCHORAGE, ALASKA 99504
Telephone (907) 337-9448 Fax (907) 337-4123

This confidential information is important for our records and your health.

PLEASE PRINT

Patient's name _____ Nickname _____
DOB _____ Age _____ Caregiver's name _____ home: _____
Patient's Employer: _____ work: _____
SS#: _____ How long employed? _____ cell: _____
Person responsible for this account? _____ Spouse name _____
SS#: _____ Lic. #: _____
Residence address: _____ city/state/zip _____
Billing address: _____ city/state/zip _____
Circle method of payment Cash Check Visa/MasterCard/Discover Grant Payee Service: _____

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

Name, Address & Phone # of nearest relative not living with you? _____
Name/Address/Phone # of your last dentist? _____
If necessary, can we request records? Y/ N _____ Date of last x-rays? _____
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: _____
Possible surgery sedation? Y/N Why? _____
Female patient: Are you pregnant? Y/N Doctor's 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? ☐ Prolonged Bleeding

☐ Stroke	☐ Anemia	☐ Diabetes	☐ Tuberculosis
☐ Heart Disease (specify)*	☐ Artificial Joints/Prosthetic	☐ Autoimmune Diseases	☐ Sinus Problems
☐ Cardiac Pacemaker	Replacements (specify)*	(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	☐ Thyroid Problems	☐ Asthma	☐ Other

* Please specify: _____
Medical history reviewed: _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____
Are you taking any medication? ☐ Yes ☐ No Please attach list with date _____
_____
Are you under a physician's care now? Y/N If so, for what? _____
How would you rate your feelings about being a dental patient? Terrified Very Nervous Relaxed Slightly Nervous
Do your gums bleed? Frequently Occasionally Never
Are you troubled with bad breath? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Patients seen in surgery center may have an additional fee. 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.

Signed: _____ Date: _____

Mabry and Mabry Dentistry, LLC
Lara Mabry, DDS
Alexander DeYoung, DDS
2601 Boniface Parkway, Suite 1
Anchorage, AK 99504
907-337-9448 907-337-4123 fax

HOSPITAL FEE LETTER

January 2023

To our patients,

You will receive a patient packet of information with a check list of what you need to do. This will include:

- An updated Patient Demographic Sheet
- Notice of failed appointment fee letter
- Policy Letter, HIPAA acknowledgement and Consent for Internet Communications
- Current Power of Attorney or Guardianship papers
- History and Physical (H & P) form
- Treatment consent forms for office and Providence

If you need to change or cancel the appointment, we **require 72 hours' notice**. If you fail to give this notice, **there will be a fee of $150.00** which cannot be billed to insurance or Medicaid. The patient has been instructed no food or water prior to surgery. If the surgery appointment needs to be canceled due to eating, **there will be a fee of $150.00** which cannot be billed to insurance or Medicaid. Our office is open 8:30am to 5:00pm; there is the ability to leave a message on our answering machine after hours. Dr. Lara Mabry may be reached on her cell at 907-351-9672. Dr. DeYoung at 907-795-5054.

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.

We appreciate the opportunity to care for our patients and the trust you have bestowed in us. We are proud to be recognized as an outstanding dental provider for our community. If you have any questions, please feel free to contact our office at 907-337-9448.

Thank you.

Received by:

Name Relationship Date

MABRY & MABRY DENTISTRY LLC
Lara M. Mabry DDS
Alexander DeYoung, DDS
2601 Boniface Parkway -- Suite 1 -- Anchorage, AK 99504 (907) 337-9448/ (907) 337-4123 Fax

INFORMED CONSENT FOR ORAL SURGERY

Patient Name: _____ DOB: _____

Procedures: Exam, Full mouth x-rays, Cleaning (including Perio Scaling and root planing if needed) decay removal and possible extractions

_____

_____

_____

*I have been informed and understand that THERE ARE INHERENT RISKS ASSOCIATED WITH PLANNED SURGICAL PROCEDURE, and there may exist certain post-operative complications or sequela that include but are not limited to pain, swelling, infections, numbness, altered sensation, bleeding, discoloration, sinus perforation, and jaw fracture. Other potential complications, may be related to the nature of the specific procedure performed and include but are not limited to: referred pain to the head and/or neck, and temporomandibular joint (TMJ or injury to crowns and/or fillings, etc..), alteration in sensation (permanent or temporary), unsatisfactory cosmetic results, need for additional surgery, loss of a tooth or teeth, sinus infection, extension of infection into other areas of the head and neck, and the need of modify existing dentures of other prosthetic devices.

*I have been complete and truthful in informing the dentist of _____ medical history, use of medications or other drugs, alcohol, smoking and allergies, I have been informed and understand the practices of dentistry and medicine are not exact sciences, and that there cannot be actual or implied guarantees that the intended result or results of a procedure will be realized. For example, teeth may be lost despite therapy aimed to preserving, restoring or enhancing them. Certain care rendered may need to be completed or followed up by additional specialists or health care providers. I understand the above written information, and I have been given the opportunity to ask questions pertaining to _____ care and the proposed procedure or procedures including fees and follow-up care. I hereby give my free and voluntary consent to the performance.

_____

Signature: _____ Date _____

Phone number: _____ Relationship: _____

Surgery Date: _____

Providence Hospital

3-Hole 1/4 2 3/4 c-to-c

2CONS

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

Patient Name: _____ DOB: _____

DO NOT SIGN UNLESS YOU HAVE THOROUGHLY READ AND YOU UNDERSTAND THIS FORM. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION PRESENTED, ASK YOUR PROVIDER BEFORE SIGNING THIS CONSENT FORM!

I hereby authorize DR. LARA MABRY / DR. ALEX DEYOUNG and his/her associates to perform the following surgery/procedure:

EXAM, FULL MOUTH X-RAYS, CLEANING (SCALING & ROOT PLANING) FLUORIDE, DECAY REMOVAL AND POSSIBLE EXTRACTIONS

1. I hereby authorize and direct the above-named provider to perform such additional services for me as they may deem necessary and reasonable, including, but not limited to the performance of services involving pathology and radiology, and the administration of blood products, and I hereby consent.
2. I recognize that, during the course of the operation, unforeseen conditions may require additional or different procedures than set forth above. I therefore further authorize and request that the above-named provider perform such procedures as are in their professional judgment, necessary and desirable. The authority granted under this paragraph shall extend to remedying conditions that are not known at the time of the beginning of the operation.
3. I hereby authorize the hospital Pathologist to use his discretion in the disposal of any severed tissue or body part.

☐ **Blood Transfusion: Possible Risks** of this blood component transfusion include but are not limited to: itching, rash, hives and/or flushing; fever and chills; difficulty breathing with elevated blood pressure; decreased blood pressure with respiratory failure; hemolysis; anaphylaxis; bacterial contamination with possible sepsis; viral infections.

Please read and initial one of the options below:

_____ The reason for recommending this operation or procedure along with the risk and alternative treatments or tests have been explained to me by my provider. My provider has provided sufficient information about this procedure or operation and I wish to proceed.

OR

_____ I have told my provider that I have elected not to have all the facts and risk explained to me and I wish to proceed.

Signature of Patient or Patient Representative (and relationship) **Date**

Reason why patient cannot sign (if signed by patient representative) _____

Witness to Patient Confirmation Statement **Relationship / Credentials** **Date**

FOR Provider USE ONLY (may be documented elsewhere in medical record):

Provider documentation of Informed Consent and risks discussed with patient, if not below, may be found:

☐ **H & P** ☐ **Progress Note** ☐ **ED Notes**

Possible Risks of this surgery/procedure include, but are not limited to: _____

PROVIDER DECLARATION: I have reviewed the anesthetics/surgery/procedure/other medical services listed above with the patient. Unless the patient has declined information as documented above, I have described the procedure, its possible risks and benefits, alternatives with their risks, including the risk of not having the procedure and the likelihood of achieving care goals. To the best of my knowledge, the patient has been adequately informed, understands the information and has consented to the procedure.

Signature of Provider **Date**

8721-602 (Rev. 4/21)

PLACE PATIENT ID LABEL HERE

PROVIDENCE
Alaska
Medical Center

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

TAB 7

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

DOCUMENTATION OF PHONE CONSENT

Patient Name: _____

Procedure: _____

_____

_____

PROVIDER DECLARATION: I have reviewed the anesthetics/surgery/procedure/other medical services listed above with the patient's Representative by phone. I have described the procedure, its possible risks and benefits, alternatives with their risks, and the likelihood of achieving care goals. To the best of my knowledge, the Representative has been adequately informed, understands the information and has consented to the procedure.

_____

Name and Relationship of Representative

Reason why patient cannot sign: _____

_____

_____ _____

Signature of Provider **Date**

_____ _____

Witness to phone consent **Date**

REFUSAL OF BLOOD

I refused to consent to the blood product transfusion recommended by my provider and accept the risks of this action, including death.

☐ I have discussed this with my provider.

_____

Signature of Patient or Representative

_____

Signature of Witness

_____

Date

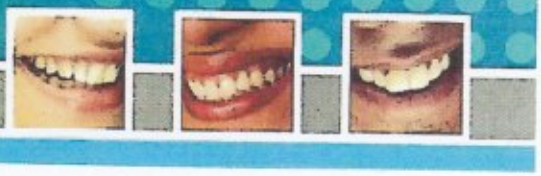
If signed by other than patient, indicate relationship: _____

(Parent, legal guardian, etc.)

PLACE PATIENT ID LABEL HERE

PROVIDENCE Alaska Medical Center

Mabry & Mabry Dentistry LLC
2601 Boniface Parkway
Suite 1
Anchorage, AK 99504
(907)337-9448



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.

PLEASE NOTIFY OUR OFFICE 24 HOURS PRIOR TO RESCHEDULING OR CANCELLING AN APPPOINTMENT. MISSED OR BROKEN APPOINTMENTS WILL BE CHARGED $25. Insurance and Medicaid will not cover this fee. We reserve the right to dismiss patients for chronic missed or short notice rescheduled appointments.

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.

☐ I have read the Office Policy above and agree to the content.

Mabry & Mabry Dentistry LLC
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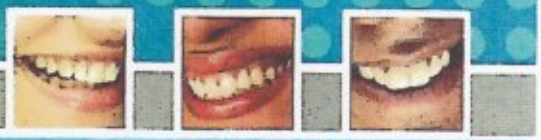

HIPAA ACKNOWLEDGEMENT

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.

☐ By checking this box, I understand the above information and agree with its contents.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

SPECIAL POWER OF ATTORNEY

I, _____

Parent/Legal Guardian of

Patient Name: _____

First Middle Last Date of Birth

Designate: _____

First Middle Last

Special power of attorney to authorize/ execute consent for surgery, anesthesia, and or dental procedures at the: ☐ Alaska Regional Hospital ☐ Providence Hospital

Date of procedure: _____

Month Day Year

Type of procedure: DENTAL PROCEDURES UNDER GENERAL ANESTHESIA

To be performed by Lara M. Mabry, DDS. or Alexander DeYoung, DDS

Name of healthcare provider

_____

Signed Relationship Date

Subscribed and sworn before me this date: _____

Month Day Year

_____

Notary Public

_____ Commission Expires:

THIS FORM IS ONLY NEEDED IF THE LEGAL GUARDIAN IS NOT ABLE TO BE AT THE APPOINTMENT. A COPY OF THE GUARDIANSHIP PAPERS NEEDS TO BE ON FILE WITH OUR OFFICE.

CANNOT BE MORE THAN 30 DAYS FROM SURGERY DATE

FAX: (907)337-4123

1HANP

Patient Name: _____ DOB _____ Admission Date _____

Present illness/chief complaint: _____

MEDICAL HISTORY: _____

_____

Hospitalizations/Past Surgeries: _____

Current Meds: _____

Allergies: ☐ NKA Latex Allergy ☐ Yes ☐ No Other: _____

REVIEW OF SYSTEM:

Head	☐ Normal	☐ Other _____		**Respiratory/Chest**	☐ Normal	☐ Other _____
Eyes	☐ Normal	☐ Other _____		**Cardiovascular**	☐ Normal	☐ Other _____
Ears	☐ Normal	☐ Other _____		**Urinary/Genital**	☐ Normal	☐ Other _____
Nose/Sinuses	☐ Normal	☐ Other _____		**Gastrointestinal**	☐ Normal	☐ Other _____
Mouth/Throat	☐ Normal	☐ Other _____		**Neuro/Psych**	☐ Normal	☐ Other _____
Neck	☐ Normal	☐ Other _____		**Musculoskeletal**	☐ Normal	☐ Other _____
Integument	☐ Normal	☐ Other _____		**Breasts**	☐ Normal	☐ Other _____
Endocrine	☐ Normal	☐ Other		**Other** _____		

Females: Grav _____ PARA _____ SAB _____ TAB _____ Living Children _____

Menses onset _____ Frequency _____ Duration _____ EDC _____ Pregnancy State Yes / No / NA

Flow _____ LMP _____ Menopause _____ Last PAP _____

Family History: Hypertension ____ Heart Disease ____ Diabetes ____ Seizures ____ Cancer ____ Mental Disorders ____

Other/Comments: _____

Pediatric Patients: ☐ N/A

Developmental age: _____ length: _____ weight/kg: _____ head circ: _____ immunization status _____

Personal/Social History: _____

Marital Status: S M W D Weight: _____ Height: _____

Tobacco: ☐ Yes ☐ No Drugs: ☐ Yes ☐ No ETOH: ☐ Yes ☐ No Caffeine: ☐ Yes ☐ No

Physical Exam/Vital Signs: RR _____ P _____ BP _____ T _____ WT _____

_____

_____

_____

_____

Impression: _____

_____

_____

_____

Goals/Plan: _____

_____

_____

_____

Date _____ Time _____ Signature _____

9691-011 (Rev. 11/07)

PLACE PATIENT ID LABEL HERE

PROVIDENCE Alaska Medical Center

HISTORY & PHYSICAL

TAB 4