WALTHER DENTAL CENTER
1700 E. BOGARD RD., BLDG. B, STE. 204 * WASILLA, AK 99654
907-376-9449 * FAX 907-376-9339
Email Address: waltherdentalcenter@gmail.com
www.waltherdental.com

Patient Full Legal Name _____ **Male**____ **Female**____

DOB _____ **SS #** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work**_____ **Cell** _____

Text Message Appointment Reminders Yes___ **No**___

E-mail address_____

Parent/Guardian _____ **DOB**_____ **SS#**_____
Print Name

Please take a moment to let us know who referred you to our office or how you heard about us?

(Examples: Internet search, Insurance PPO list, a friend/family member? Please list below)

_____

Who was your last dentist? _____ **Last time you had dental x-rays?** _____

Have you had any dental treatment in the last 3 years? (Such as fillings, crowns etc.) _____

_____

	Primary Insurance	**Secondary Insurance**
Employer	_____	_____
Carrier	_____	_____
Phone #	_____	_____
Group #	_____	_____
Name of Subscriber	_____	_____
Date of Birth of Subscriber	_____	_____
Social Security # of Subscriber	_____	_____
Insurance ID #	_____	_____

Please like our Facebook page for exciting news about our office and to follow the no cavity club winners! ☺️

Walther Dental Center

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taker Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a specia diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifica	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:

WALTHER DENTAL CENTER
Family Dentistry
1700 E. Bogard Road, Bldg. B. Ste. 204 Wasilla, AK 99654

Financial Agreement

All patients, please read the following…

Payment for services is expected at the time service is provided. **Cash, checks, Visa and MasterCard** are accepted forms of payment. Any checks returned by the bank will be assessed a $40 NSF fee.

If an extended payment plan is desired, please ask us about the **CareCredit** program. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. **Finance charges will be applied to all past due amounts at the rate of 1.5% per month (18% annual rate).**

If you have dental insurance….

As a courtesy, we will file your claim for you. We will **estimate** your deductible and the portion not covered by your insurance, **which is due at the time of treatment**. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about the "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Keep in mind that all insurance companies have limitations that may prevent payment on certain types of services. Limitations may include frequency of procedures, missing tooth clause.

Any insurance claims denied or remaining unpaid after 40 days will automatically become the responsibility of the patient. This includes Denali Kid Care or Medicaid patients.

I also understand a $50 per hour fee will be assessed for missed appointments or cancellations without at least 2 business days notice.

I have read and understand this financial agreement.

_____ _____

Print Name Signature

_____

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices. (If you would like a copy to take home please ask the front desk.)

_____

Print Name

_____

Signature

_____

Date

I authorize _____ to have access to my:

____ Records
____ Account

_____

Signature

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)

_____

_____

Walther Dental Center
Records Release Form, From Previous Dentist
www.waltherdental.com

waltherdentalcenter@gmail.com
1700 Bogard Road #B204
Wasilla, AK 99654
907 376-9449
Fax: 907 376-9339

I, _____, hereby authorize
Print name

_____
Name and address of Previous Dentist

to release the dental records of_____
Name of Patient (please print)

Patient's date of Birth_____

To Walther Dental Center at the above named address. These records should include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to dental treatment.

_____

_____

_____

_____
Signature of patient or guardian

Date: _____

Walther Dental Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Walther Dental Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Walther Dental Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Danielle Cole (Office Manager).

If you believe that Walther Dental Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Danielle Cole (Office Manager), 1700 E. Bogard Rd. Ste. B204, Wasilla, AK 99654, (907) 376-9449, Fax – (907) 376-9339, waltherdentalmgr@gmail.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Danielle Cole (Office Manager) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.