bty DENTAL Group LLC.
T: (907) 333-6666 F: (907) 333-3390
www.btydental.com

Patient Name: _____
LAST FIRST MIDDLE

Gender: ◯ MALE ◯ FEMALE **Marital Status**: ◯ Married ◯ Single ◯ Child ◯ Other: _____
Social Security #: _____ / _____ / _____ **Date of Birth:** _____ - _____ - _____
Address: _____ **City, State:** _____ **Zip Code:** _____
Phone (Cell #1): _____ **(Cell #2):** _____
Employer: _____ **Work#:** _____
Email: _____ **Emergency Contact#/Relation:** _____

Medical History

Reason for Visit/Area of Concern: _____ **Date of Last Dental Visit:** _____

Have you even been prescribed a blood thinner or bone density medication? (Fosamax/Plavix/Coumadin/Aspirin) **YES/ NO** ☐
Are you **ALLERGIC** to: Aspirin/Penicillin/Codeine/Latex/Local Anesthetic/Other: _____ **YES/ NO** ☐
Have you ever had any complications following dental treatment? **YES,** explain: _____ **YES/ NO** ☐
Have you been admitted to the hospital or needed emergency care in the past two years? _____ **YES/ NO** ☐
Explain: _____
Are you under the care of a physician now? **YES,** explain: _____ **YES/ NO** ☐
Physician: _____ Office Name: _____ Phone #: _____
Do you have any **HEART PROBLEMS**: **YES,** explain: _____ **YES/ NO** ☐
Have you ever been told you needed **PRE-MEDICATION** (antibiotic): _____ **YES/ NO** ☐

FEMALES-Are you or could be PREGNANT at this time? **YES, DUE DATE:** **Trimester:** 1st ☐ 2nd ☐ 3rd ☐ **YES/ NO** ☐

Please check **ALL** that apply:

- ☐ AIDS/ HIV (circle)
- ☐ Allergies: _____
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes Type I or II
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma (Acute / Open)
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Hepatitis A/ B/ C
- ☐ High or Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ OTHER: _____ _____ _____
- ☐ ***NONE***

Are you currently taking any medications? ☐ ***NONE*** If **YES,** please list:
_____
_____

To the best of my knowledge, all of the preceding answers and the information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

X _____

Signature of Patient (If patient is a minor, Parent or Guardian) **Date**

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Financial Policy of btyDENTAL

We are committed to providing you with the best possible care. As a professional courtesy, if you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policies.

_____ Initials **– Payment is due at the time of service, including any deductibles or co-payments**. We accept the following forms of payment:

1. **Cash**
2. **Credit Card- Master Card/ Visa/American Express/ Discover**
3. **Care Credit**- offers a separate line of credit to cover your entire family's health care needs. (Please ask the office staff for more information)

_____ Initials **– Insurance Billing**

You are expected to alert us in full disclosure of all of your dental insurance plans. We will contact your insurance company for you to inquire about your eligibility and benefits, therefore, we will need all of your insurance information at your initial visit. We will work to the best of our ability to accommodate your needs and provide you with the options allowed by your insurance, will inform you of the co-pay, and any other costs that are associated with your appointment before we begin your treatment; with the following stipulations:

- **You are expected to pay in full your co-pay upfront. We will calculate your total for you and present you with cost breakdowns. You will be made aware of any additional payment required for treatment beforehand.**

- **Ultimately the balance of your account is your responsibility. While we will do our best to obtain accurate information regarding your eligibility and benefits, in rare cases the insurance companies will not always provide us with the most up to date information resulting in inaccuracies. In this scenario we will require you to pay the remaining balance. Your insurance policy is strictly between you and your insurance company, we are not privy to it. We do offer Care Credit as a payment plan option; please feel free to ask any of our staff how to apply.**

- **We will allow a 60 day period in which you can pay the remaining balance after we have informed you that it is due. If you do not pay in the allotted time your account will be considered overdue.**

_____ Initials **– Overdue Accounts**

Accounts with a balance over 60 days will be turned over to Cornerstone Collection Agency. We have a payment plan option through Care Credit if you wish to make use of this. Once an account has been referred for collection, the doctor-patient relationship is considered terminated. Your records will be referred to a dentist of your choice.

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Better Than Yesterday Dental is named rightfully so by our core mission. We want to provide you with a better today. We believe in dentistry that goes beyond excellent dental care, beyond providing you with amazing customer service to the point of taking you to what truly matters, your life. We believe that through our hard work and passion we can create something greater than our dental group and that we can change the world, one smile at a time, starting with yours. At the end of the day our mission is not about us but rather about you.

You can learn more about our mission and purpose by visiting our website: www.btydental.com, our facebook page: facebook.com/btyDENTAL or our twitter. We are excited to have several locations in Anchorage to serve you. We are currently located at:

- ✓ 1136 North Muldoon Road Suite 110 Anchorage, Alaska 99504
- ✓ 4211 Mountain View Drive Suite 102 Anchorage, Alaska 99508
- ✓ 3565 Arctic Boulevard Unit D1-2 Anchorage, Alaska 99503
- ✓ 726 East 9th Avenue Anchorage, Alaska 99501
- ✓ 1921 West Dimond Boulevard Unit D1-2 Anchorage, Alaska 99515

More Locations Coming soon!

Adult Medicaid Only (over 21 years):

You have a total of **$1150** in dental benefits to use toward dental work each Medicaid fiscal year (July 1st – June 30th). Although we check the amount you have available for use, it is your responsibility to disclose any other dental visits you have had during the last year so that we can more accurately calculate how much money you have left.

In the event that you do not disclose any dental visits within the last fiscal year and the Medicaid office gives us an inaccurate amount that you have available to use, you are responsible for any difference in cost for services received. Please help us serve you better by letting us know your dental history.

I have read and agree to the terms above. I will disclose to btyDENTAL any recent dental visits or appointments made at other dental offices (within the last year) so that they can ensure I do not have to make any additional payments.

Signature _____ **Date** _____

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Consent Laws for Minors

When a dentist has a minor as a patient and that minor ends up needing restorative work done or treatment outside of a typical cleaning, the dentist must obtain permission from the child's parent or guardian before the treatment can legally begin. Such permission should always be properly documented in the minor's patient chart. Parents who cannot physically bring their child in may send a permission note with the child allowing the dentist to do all necessary work. If the parent has not sent a permission note, and is not with the child at the actual dental office, the dentist must receive permission over the phone from the child's parent or legal guardian before doing any restorative work. In the event the child's parents are divorced, consent must be obtained from whichever parent has legal custody of the child.

Minors Being Left Alone

In some circumstances, a minor may legally be left alone in a dental office while being operated on. For example, if the minor is over the age of 10, they may be left alone during their dental visit. For routine dental procedures, such as fillings, fluoride treatment or cleaning, the minor may be left alone only if the parent or guardian has given permission and will be accessible by phone. Parents and legal guardians may also leave their child alone in a dental office or not be present at all if they contact the dentist ahead of time to arrange for the child to be there unaccompanied by a parent.**Please be aware that dental treatment can change while you are away.**

I have read the above terms/conditions and fully comprehend and will oblige to the best of my abilities. I understand that I am also allowed to bring in written consent, in case of an emergency, for the afore mentioned minor along with contact information where I am reachable at all times.

_____	_____
Print Child's Name	**Print Parent/Legal Guardian**
_____	_____
Signature	**Date**

Behavior Management - Medicaid Only (Under 21 years):

I understand that various basic behavior guidance methods will be used to help guide the patient through the dental experience and make it a pleasurable one. In the case that those methods are unsuccessful, other advanced behavior guidance methods might be utilized: lap to lap technique, protective stabilization (restriction of patient's movement with wrist bands, by dental personnel, or a combination of both), or oral conscious sedations.

_____	_____
Signature	**Date**

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Parent/Legal Guardian Consent for Dental Treatment

_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	(____)_____-_____
Parental/Legal Guardian Contact	Phone Number

Authorized Caregiver's Information

_____	(____)_____-_____	(____)_____-_____
Caregiver's Name	Home Phone Number	Cell Phone Number

The above named caregiver shall be authorized to provide consent for all dental treatment, for the above named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

If circumstances permit and/or if btyDENTAL needs to contact me, please contact me at the following telephone number:(_____)_____-_____

This consent serves as permission for treatment by btyDENTAL for the above named child(ren). This authorization shall be effective until _____: One (1) year from date signed.

OR

Until _____/_____/_____ (list Month, Day, Year)

This authorization will remain in effect until the date stated above- unless I revoke this authorization in writing and submit it to btyDENTAL prior to this date.

_____	_____	_____	_____
Parent / Legal Guardian **(circle one)**	Date	Witness	Date

*****Note: Consents are NOT required in emergency situations*****

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NOTICE OF PRIVACY PRACTICES

(Please Read carefully and Take this with you)

Under the Health Insurance Portability and Accountability Act of 2013 (HIPAA) we are required to inform you of our privacy policy. We use the personal and health information you provide us to assess your condition and provide treatment within our office. Only the doctor and employees have access to your personal and health information. Your information will not be released to outside parties without your consent or for non-medically related purposes.

We may provide your information to Insurance Plans, 3rd Party Billing Services, or Direct Reimbursement Plans for payment. We may provide your information to collection services. We may provide your information to pharmacies for drug prescription services. We may provide your information to health care providers for consultation purposes, or referrals. If you pay 100% out of pocket you have the right to request that your information not be released to your health plan unless it is necessary for treatment purposes or required by law.

You have a right to a written copy of our privacy policy. You have a right to see, amend, and get copies of your records. You have a right to complain about privacy violations. Your consent must be obtained before the information in your records can be disclosed for treatment, payment, or any health care operations. We will contact you if there is a breach of your Protected Health Information.

If you want more information about our privacy practices, have questions or concerns, or if you are concerned that we may have violated your privacy rights, please contact: **General Manager for btyDENTAL at 907-333-6666.**

By signing the Acknowledgement of receipt form, you have given us permission to release your personal and health information for health care and dental consultations and referrals, billing, collections, and drug prescriptions. If you refuse to sign the Acknowledge of Receipt form, we will not be able to utilize your dental insurance as a means of payment.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgement

I,_____ have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

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)

_____

_____