DR. JESSE HRONKIN, DMD

Alaska Comprehensive DENTAL Center

Welcome! *Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.*

Patient Information (CONFIDENTIAL)

Today's Date: _____

Name: _____ *Nick Name:* _____ *Birth date:* _____

*Soc. Sec. #:*_____ *Home Phone:*_____ *Work Phone:*_____ *Cell Phone:*_____

Address: _____ *City/Zip:* _____

E-Mail: _____ *Employer:* _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* ☐ *Other* _____

If Student Name of School/College: _____ *City/State:* _____ ☐ *Full Time* ☐ *Part Time*

Spouse, Parents or Nearest Relative Name: _____ *Contact Number:* _____

Contact in Case of Emergency: _____ *Contact Number:* _____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account if Other Than You: _____

Address: _____ *City/Zip:* _____ *Contact Number:* _____

Birth date: _____ *Soc. Sec. #:*_____ *Employer:*

_____

*Home Phone:*_____ *Work Phone:*_____ *Cell Phone:*_____ *Currently a Patient in Our Office?* ☐ *Yes* ☐ *No*

Dental Insurance Information

Name of Person Carrying Insurance: _____ *Birth date:* _____

Soc. Sec. #: _____ *Name of Employer:* _____ *Union or Local #:* _____

Work Phone: _____ *Relationship to Patient:* ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other:* _____

Insurance Company: _____ *Group #:* _____ *Policy/ID #:* _____

Ins. Co. Address: _____ *Ins. Co. Phone Number:* _____

Do You Have Any Additional Dental Insurance? ☐ *Yes* ☐ *No* *If Yes, Complete the Following:*

Name of Person Carrying Insurance: _____ *Birth date:* _____

Soc. Sec. #: _____ *Name of Employer:* _____ *Union or Local #:* _____

Work Phone: _____ *Relationship to Patient:* ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other:* _____

Insurance Company: _____ *Group #:* _____ *Policy/ID #:* _____

Ins. Co. Address: _____ *Ins. Co. Phone Number:* _____

Patient Medical History

Physician and Location: _____ *Office Phone:* _____ *Date of Last Exam:* _____

	Yes	No
!. Are you under medical treatment now……..	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 Years? If Yes, please explain: _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medication(s)?..... If Yes, please list: _____ _____	☐	☐
4. Do you use tobacco?.....	☐	☐
5. Do you use controlled substances?.....	☐	☐

	Yes	No
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (ex. Novocain)……..	☐	☐
Penicillin or other antibiotics…….....	☐	☐
Sulfa drugs…….....	☐	☐
Barbiturates…….....	☐	☐
Sedatives…….....	☐	☐
Iodine…….....	☐	☐
Aspirin……..…..…	☐	☐
Any metals (ex. nickel, mercury, ect.)……..	☐	☐
9. Women Only:		
Are you pregnant or think you may be pregnant?.....	☐	☐
Are you nursing?.....	☐	☐
Are you taking oral contraceptives?.....	☐	☐

7. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure……..	☐	☐
Heart Attack……...	☐	☐
Rheumatic Fever……...	☐	☐
Swollen Ankles……	☐	☐
Fainting / Seizures……...	☐	☐
Asthma……...	☐	☐
Low Blood Pressure……...	☐	☐
Epilepsy / Convulsions……..	☐	☐
Leukemia……	☐	☐
Diabetes……..	☐	☐
Kidney Diseases……	☐	☐
AIDS or HIV Infection……	☐	☐
Thyroid Problem……...……	☐	☐

	Yes	No
Heart Disease……...	☐	☐
Cardiac Pacemaker……	☐	☐
Heart Murmur……..	☐	☐
Angina……	☐	☐
Frequently Tired…….....	☐	☐
Anemia…….....	☐	☐
Emphysema……...	☐	☐
Cancer……	☐	☐
Arthritis……..	☐	☐
Joint Replacement or Implant....	☐	☐
Hepatitis / Jaundice…….....	☐	☐
Sexually Transmitted Disease...	☐	☐
Stomach Troubles / Ulcers…..	☐	☐

	Yes	No
Chest Pains……..	☐	☐
Easily Winded……..	☐	☐
Stroke……	☐	☐
Hay Fever / Allergies……	☐	☐
Tuberculosis……..	☐	☐
Radiation Therapy……	☐	☐
Glaucoma……	☐	☐
Recent Weight Loss……...	☐	☐
Liver Disease…….....	☐	☐
Heart Trouble……..	☐	☐
Respiratory Problems……..	☐	☐
Mitral Valve Prolapse……...	☐	☐
Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location: _____ *Date of Last Exam:* _____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?..	☐	☐
3. Are your teeth sensitive to sweet/sour liquids/foods?..	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have sores or lumps in /or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems in you jaw?		
Clicking……	☐	☐
Pain (joint, ear, side of face)……	☐	☐
Difficulty in opening or closing……..…...	☐	☐
Difficulty chewing……	☐	☐

	Yes	No
8. Do you have frequent headaches?.....	☐	☐
9. Do you clench or grind your teeth?.....	☐	☐
10. Do you bite your lips or cheeks frequently?.....	☐	☐
11. Have you ever had any difficult extractions?.....……....	☐	☐
12. Have you had any prolonged bleeding following extractions……	☐	☐
13. Have you ever had any orthodontic treatment……..……..	☐	☐
14. Do you wear dentures or partials?..... If Yes, date of placement_____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of you teeth and gums?.....	☐	☐
16. Do you like your smile?.....	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the periods of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If there is anything I do not understand regarding my dental treatment, I will ask someone.

*Patient Name:*_____ *Signature:* _____ *Date:* _____

Relationship to patient (if filled out and signed by representative of patient): _____