Welcome!

Troy E. Aland, DDS

Aland Family Dentistry

Whom may we thank for referring you? _____

Patient Information

Name: _____ M / F SS#: _____ Preferred Name: _____

DL#: _____ DOB: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

Responsible Party Name: _____ Address: _____

Responsible Party SS#: _____ Phone: _____

Emergency Contact Name: _____ Ph#1: _____ Ph#2: _____

Insurance Subscriber Information

(Please Give Drivers License Or State Issued ID And Dental Insurance Card To Receptionist To Copy For File)

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber Address: _____

Employer: _____ Insurance Co: _____ Group#: _____ Ph#: _____

Medical History

Are you currently under the care of a Physician or Specialist: Y/N Name: _____ Ph# _____

If yes, please explain: _____

Have you been hospitalized for surgery or serious illness in the last 5 years? Y/N

If yes, please explain: _____

Are you currently taking any prescription and/or over-the-counter drugs/supplements: Y/N

Please List: _____ _____ _____ _____ _____

Have you ever been told you need to pre-medicate for appointments? Y/N

Are you currently pregnant? Y/N Weeks: _____ Are you nursing? Y/N

Have you ever had any of the following diseases or medical problems? (Circle all that apply)

Abnormal Bleeding	Alcohol/Drug Abuse	Anemia	Arthritis	Asthma	Stroke
Artificial Joint/Valves	Blood Transfusion	Cancer	Colitis	Diabetes	Emphysema
Difficulty Breathing	Fainting Spells	Epilepsy	Glaucoma	Sinus/Hay Fever	HIV/AIDS
Frequent Headaches	Heart Attack	Hemophilia	Hepatitis	Seizures	Shingles
Heart Murmur	Heart Surgery	Pacemaker	Heart Disease	Mitral Valve Prolapse	STD's
Low Blood Pressure	Liver Disease	Thyroid Problems	Tuberculosis	Radiation Treatment	Ulcers
Rheumatic Fever	Sickle Cell Disease	Mental Health	High Blood Pressure	Kidney Problems	

Other: _____

Do you smoke or use chewing tobacco? Y/N How often? _____ How often do you brush? _____

Do you regularly drink soda? Y/N How much per week? _____ How often do you floss? _____

Do your gums bleed while brushing or flossing? Y/N Are your teeth sensitive to: Hot / Cold / Sweet / Sour (Circle all that apply)

Do you wear dentures or partials? Y/N If yes, indicate placement date: _____

Are you allergic to any of the following? (Circle all that apply)

Aspirin Barbiturates Metals Codeine Jewelry Penicillin Dental Anesthetics Sulfa Drugs Latex

Other: _____

I have answered all the above truthfully and to the best of my knowledge.

_____ _____

Patient/Guarantor Signature Date

Aland Family Dentistry's Financial Policy

Welcome to Aland Family Dentistry! We look forward to serving you and your family for years to come.

All fees incurred for services rendered by Aland Family Dentistry, Dr. Aland and all employees and/or associates are due at the time services are rendered. All estimated co-payments and deductibles, as determined by our staff, will be collected prior to treatment commencing. Any portions not covered by your insurance company are the patient's/guarantor's full responsibility and are due within 30 days of insurance benefit payment being received.

Please initial all the following to indicate agreement:

1) _____I understand the above statement and that I am responsible for all fees incurred in this office.
2) _____I understand I will receive a detailed estimation of all co-payments and deductibles due at my appointments.
3) _____I understand co-payments/deductibles, as estimated by employees, are due prior to treatment commencing.
4) _____I understand my employer negotiated my insurance contract, not Aland Family Dentistry or its employees. If I have a dispute with my insurance company, I will inform my employer.*
5) _____If my coverage is terminated or I have not updated my insurance coverage, I am fully responsible for all fees incurred regardless.
6) _____Aland Family Dentistry has a cancellation/reschedule policy charging $75/hr for hygienists and $150/hr for the doctor. ***I will give 48 hours notice if I need to cancel or reschedule to avoid fee(s).***

* (Aland Family Dentistry is here to serve you. If you have a dispute with your insurance company, we will assist in any way we can. We house an insurance specialist who resubmits incorrectly paid claims. We will attempt to help ensure that your insurance company is giving you every benefit you deserve within contractual limits.)

I authorize Aland Family Dentistry to provide my Insurance Company with any information needed to process my claims for payments, and/or my dependent's claims.

_____ _____
Subscriber Signature Date

I authorize my insurance company to release all benefit payments for myself and/or dependent(s) directly to Aland Family Dentistry and/or Dr. Aland.

_____ _____
Subscriber Signature Date

HIPAA (Health Insurance Portability & Accountability Act of 1996)

This office strives for complete HIPAA compliance and will always protect your personal information as if it is our own. We have included a document explaining your rights under the Health Insurance Portability & Accountability Act of 1996. We highly recommend you call your insurance company and ask them to use an alternate ID number, other than your social security number, on all of your insurance cards. Also, if you would like someone else to have the ability to discuss your treatment or account, and/or a dependent's, we must receive an authorization **in writing** from you.

I have reviewed all compliance information from Aland Family Dentistry and understand Aland Family Dentistry will protect my information as if it is their own.

_____ _____
Patient or Patient's Representative Date

Welcome to our family!