

Aesthetic Family Dentistry, LLC
Scott A. Methven, D.D.S.
1551 W. Parks Highway
Wasilla, AK 99654

Our Office Policies

Welcome to our office and thank you for choosing Aesthetic Family Dentistry to serve your dental needs. Our dental team is dedicated to providing the highest quality dental care and service to our patients.

We ask that you take a couple of minutes to thoroughly read over our office policies. *If you have any questions, please direct them to our Front Desk Coordinators, they will be happy to answer any questions you may have.*

Appointments

We see patients on an appointment basis only (with the exception of emergencies), and we consider an appointment made to be an agreement and a commitment between our office and our patients.

Regular Visits

Regular follow-up preventative care is very important in maintaining long lasting dental health. We encourage our patients to return for their recommended visits. We will advise you of when you are due for your next visit and will help you to schedule an appointment date and time that best suites you and your schedule.

Emergencies

If you have an emergency, please call the office right away and we will do everything possible to get you in at the earliest opportunity. If we are out of the office or it is after hours, we have an answering machine with instructions on how to reach Dr. Methven.

Please understand we try to keep your waiting time to a minimum, your time is valuable. We will do all we can to work you into our schedule and, we do appreciate your patience while you wait.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES FOR AESTHETIC FAMILY DENTISTRY. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE, AND I AGREE TO COMPLY WITH ALL POLICIES. I CERTIFY THAT ALL INFORMATION THAT I PROVIDE TO AESTHETIC FAMILY DENTISTRY, LLC IS CORRECT AND TRUE.

Signature _____ **Date** _____

**Aesthetic Family Dentistry LLC
Scott A. Methven, D.D.S.
1551 W. Parks Highway**

DATE: _____ NAME: _____

MAILING ADDRESS: _____

City: _____ STATE: _____ ZIP: _____ SSN: _____

HOME PHONE _____ WORK PHONE: _____

OTHER PHONE: _____

HOW DID YOU HEAR ABOUT US: _____

SEX: Male _____ Female _____ Age: _____ BIRTH DATE: _____ Married: _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE # _____

OTHER FAMILY MEMBERS IN OUR PRACTICE? _____

ARE YOU COVERED BY ONE OR MORE INSURANCE PLANS? _____

PRIMARY INSURANCE / GUARANTOR INFO

SUBSCRIBERS'S NAME: _____

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE: _____ EMPLOYER: _____

OCCUPATION: _____ Work phone: _____

BUSINESS ADDRESS: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: _____ GROUP NUMBER _____

**I hereby authorize and direct payment of the dental benefits otherwise payable to me,
directly to the above named dental entity.**

SIGNATURE: _____ DATE: _____

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SECONDARY INSURANCE

SUBSCRIBERS'S NAME: _____

SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____ EMPLOYER: _____

OCCUPATION: _____ WK. PHONE: _____

BUSINESS ADDRESS: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: _____

GROUP NUMBER: _____

**I hereby authorize and direct payment of the dental benefits otherwise payable to me,
directly to the above named dental entity.**

SIGNATURE: _____ DATE: _____

Patient Name: _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT: _____

PREVIOUS DENTIST: _____ PHONE NUMBER: _____

DATE OF LAST DENTAL CARE: _____ LAST DENTAL XRAYs: _____

PLEASE CHECK IF YOU HAVE CONCERNS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Broken Teeth | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sores in your Mouth |
| <input type="checkbox"/> Fear of Dental Treatment | <input type="checkbox"/> Lost or Broken Fillings | |

HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT? _____

PREVIOUS HOSPITALIZATIONS, ILLNESSES, OR OPERATIONS (Please describe and give approximate date.) _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO IF YES, APPROX. DATE _____

WOMEN: ARE YOU PREGNANT? YES / NO / NURSING? YES / NO BIRTH CONTROL? YES

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis, Type _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Chemical Dependency | Describe _____ | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |

Dr.'s Notes: _____

LIST ANY MEDICATIONS YOU ARE TAKING: _____

ANY ALLERGIES (Including Medications): _____

TREATMENT CONSENT AND FINANCIAL AGREEMENT

I, the undersigned, consent to treatment which is advisable and agreeable to both myself and the Dentist with the realization that certain rare and infrequent complications may occur. These may include the following:

- 1) Injury to adjacent restorations, teeth or other tissue.
- 2) Trismus: prolonged stiffness of muscles.
- 3) Fistula: Small openings between the mouth and sinus following the removal of upper teeth.
- 4) Fracture of bone.
- 5) Paresthesia: Nerve involvement that may result in numbness of the lip, chin, teeth, gums, or tongue.
- 6) Dry Socket.

I understand that there can be no guarantee as to any treatment result or cure. I realize that additional procedures may become apparent during treatment and allow the Dentist to utilize his judgment..

Signed: _____ Date: _____

(Patient or person authorized to consent)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____ have received a copy of this
Office's Notice of Privacy Practices.

Please Print Name

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)

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