Phone: 907-376-8400

www.auroradentalak.com

4501 E. Snider Drive

Wasilla, AK 99654

Welcome to Aurora Dental Care!

We're so glad you're here! We know you hate paperwork and we feel your pain ☺

That being said, compliance and ethics are an integral part of our mission. As inconvenient as these requirements are, we are committed to maintaining a high level of adherence to HIPAA, insurance and other rules. Please be sure to fully complete every page and sign where required so we have the information we need to serve you.

We know that going to the Dentist may not be on your list of favorite things to do. We can't wait to show you what a great experience going to the Dentist can be. Whether it's been 6 months or six years (or more) since your last dental visit, we're just glad that you are here.

We want you to be so happy with our care that you share your experience with your friends and family, it's the highest compliment you can give to us and we promise to honor your referrals with the same level of service we provide to you.

If you have any questions at any point in your relationship with our practice or you have an idea to make us even better at what we do, please let us know. We welcome your input. You can even call Dr. Nick personally on his cell phone at (907) 841-1880.

Warmest Wishes,

Aurora Dental Care

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Patient Name:_________________________________ DOB: _______________

Reason for today's visit: ____

Physician's name and phone: ____

Previous dentist: _________________________ Phone: _______________ Date of last appt:_______________

Last dental x-rays: _________________Have you ever been diagnosed or treated for periodontal disease? Yes/No

Please indicate any of the following issues that apply with a ☒:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to Cold
- ☐ Bleeding Gums
- ☐ Loose Teeth
- ☐ Sensitivity to Heat
- ☐ Clicking or Popping Jaw
- ☐ Broken Teeth
- ☐ Sensitivity when Biting
- ☐ Food Collection Between Teeth
- ☐ Periodontal Treatment
- ☐ Sores in your Mouth
- ☐ Fear of Dental Treatment
- ☐ Lost or Broken Fillings

How often do you floss? _______________ How often do you brush? ______________

Within the last year have you had any Hospitalizations, Illnesses, or Operations? ☐Yes ☐No

If YES, please describe: ____

Have you ever had a blood transfusion? ☐YES ☐ NO If YES, *approximated* date: ____________

WOMEN: Are you taking Birth Control? ☐YES ☐ NO

Are you pregnant? ☐ YES ☐NO ☐MAYBE Are you nursing? ☐ Yes ☐No

Please indicate any of the following issues with a ☒:

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

List *all* the medications you are taking:____

____

ANY ALLERGIES? (*including medications*): ____

TREATMENT CONSENT

I consent to treatment which is advisable and agreeable to both myself and the dentist knowing that certain rare complications may occur. These may include the following: Injury to adjacent restorations, teeth or other tissues, *trismus*: a prolonged stiffness of muscle(s), *fistula*: small openings between the mouth and sinus following the removal of upper teeth, bone fractures, *paresthesia*: a nerve involvement that may result in numbness of the chin, tongue, teeth, lips, or gum, dry socket.

I understand that there isn't a guaranteed outcome for any treatment result or cure. I realize that additional procedures may become apparent during treatment and I allow the Dentist to utilize his judgment.

SIGNATURE: ____ DATE:____________________

YEARLY UPDATE: Are there any new changes? ☐ Yes ☐ No

SIGNATURE: ____ DATE:____________________

PATIENT OR RESPONSIBLE PARTY

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Patient Information

Please Print

Circle one: Dr/Mrs/Mr/Ms/Miss

First Name: ______________ Middle Initial: _____ Last Name: __________________________

Mailing Address: ____

City, State: ______________ ZIP:____________ SSN:________________________________

Home Phone: ____________________ Work Phone: _________________________

Cell Phone: _________________________ Other Phone: _________________________

Sex: ☐ Male ☐Female Age: ________ Birth Date: ___________
Married: ☐ Yes ☐No

Employer: _________________________ Occupation: ___________________________

Emergency Contact: ______________________ Phone #: _____________________________

Preferred Pharmacy: __________________________ Phone#: _____________________________

How did you hear about our practice? ___Transferring Patient of Dr. Nick ___Newspaper ___Radio
___Google ___Website ___Mailer ___Other (please describe)_________________________________

If you were referred to our office by a friend or family member, we'd like to send them a great big thank you for their trust in our ability to serve you. Please tell us who referred you to our office:

____

Do you have any other family members in our practice? ☐ No ☐Yes: Who? ______________________

Permission to release private health information

☐ Please Don't Share Dental Information
By checking box, you don't have to fill out any further information.

I hereby give permission to the following people to have access to my private health information:

Name: _________________________________ Relationship: _______________________

Name: _________________________________ Relationship: _______________________

I give permission to employees of Aurora Dental Care to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing Aurora Dental Care's Privacy Practices and shall remain in effect until revoked.

Patient Signature: ____ Date: _________________

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INSURANCE INFORMATION

☐**NO INSURANCE:** *By checking this box, I acknowledge that all fees are due on the date of service.*

PRIMARY INSURANCE

SUBSCRIBERS'S NAME: ____

SOCIAL SECURITY #: ____________________ RELATIONSHIP TO PATIENT:__________________

BIRTH DATE: _______________ EMPLOYER: ____________________________________

OCCUPATION: ______________________________Work phone: _____________________

DENTAL INSURANCE COMPANY: ____

INSURANCE PHONE (on card): ______________________GROUP NUMBER (on card)___________

INSURANCE ID NUMBER (on card): _____________________________________

SECONDARY INSURANCE ***NOTE: IT IS YOUR RESPONSIBILITY TO BE CERTAIN WHICH POLICY IS PRIMARY AND WHICH IS SECONDARY. IF YOU PROVIDE US WITH INACCURATE INFORMATION RESULTING IN THE NEED FOR RE-BILLING, WE MAY APPLY A FEE OF $15.00 PER CLAIM. YOU HAVE NO IDEA WHAT A LABORIOUS TASK IT IS TO REBILL DUAL INSURANCE AND WE REALLY WANT TO HELP YOU AVOID PUTTING EITHER OF US IN THAT SITUATION. PLEASE, IF YOU AREN'T SURE, DOUBLE CHECK AND LET US KNOW IMMEDIATELY.***

SUBSCRIBERS'S NAME: ____

SOCIAL SECURITY #: ____________________ RELATIONSHIP TO PATIENT:__________________

BIRTH DATE: _______________ EMPLOYER: ____________________________________

OCCUPATION: ______________________________Work phone: _____________________

DENTAL INSURANCE COMPANY: ____

INSURANCE PHONE (on card): ______________________GROUP NUMBER (on card)___________

INSURANCE ID NUMBER (on card): _____________________________________

*Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of benefits paid on your behalf. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company.*

PATIENT SIGNATURE: ________________________________ DATE: _________________

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

You May Refuse to Sign this Acknowledgement

I, ____, have received a copy of Aurora Dental Care's Notice of Privacy Practices.

____
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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PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

Our office would like to communicate with you electronically via email and/or text. We use these methods to remind you of your reserved appointments and occasionally to let you know about our practice. By utilizing our practice's electronic services, you agree that Aurora Dental Care may communicate with you regarding any selected information below to the email and/or cell phone number you give us.

☐ **DECLINE SERVICE**

PATIENT CONSENT:

I, ______________________________, in the presence of my dentist or the dental practice's privacy representative, agree that the practice may electronically communicate with me at the following email address and/or cell phone number:

EMAIL ADDRESS: ____

CELL PHONE #: ____

PATIENT'S DATE OF BIRTH (*for verification purposes*): ________________________
I acknowledge that the practice may send the following to my email and/or cell phone:

Check and **initial** each item that applies:

- ☐ Information about my invoice or accounts payable. _______
- ☐ Information about any dental visit including appointment reminders _________
- ☐ Information about the practice, newsletters, promotions etc.

ACKNOWLEDGEMENT:

Before we can communicate electronically with you, you must acknowledge by initialing each of the following:

________Email communications from our practice will be encrypted.
________I am responsible for updating my email address with the dental practice.
________I am able to receive information electronically and store it securely away from any publicly accessible computers.
________ I can withdraw my consent for electronic communication by calling (907) 376-8400

PATIENT SIGNATURE: _______________________________ DATE: _________________

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OFFICE POLICIES

Appointment Commitment & Payment Policies

Sometimes while you are receiving dental care, it can be easy to forget that we are also a business. Our goal is to be compassionate about our billing practices while providing you the most accurate estimates possible. In order to achieve this goal we prefer to make our expectations clear before your first visit. If you need clarification or have questions, please let us know.

Appointment Commitment: We consider an appointment confirmed when it is scheduled and we reserve time specifically for you with our providers depending on what we deem will allow us to best serve you. Our office is different in that we are not scheduling multiple patients at the same time unless there are special circumstances like a dental emergency. This allows us to best serve you and to run on time which is a priority in our office. Accordingly, we expect our patients to keep their reserved appointments.

When we reserve an appointment, our provider is counting on you to be here.

Missed or short notice cancellations are not acceptable to the level of care and service we strive to provide. If you must cancel or reschedule your appointment, please give us at least two business days' notice; otherwise, a cancellation fee of **$50.00 per hour** may be applied to your account. We will ask you to pay this fee prior to scheduling further appointments. If you miss an appointment due to extenuating circumstances, please let us know so we may evaluate your situation with the compassion and empathy it deserves.

Insurance Practices: We accept a variety of different insurance plans and are in network with Premera BCBS of Alaska and Washington, Delta Premier, MODA, ODS, Cigna, Medicaid and DKC. Don't worry if your insurance company isn't on our list, we see many patients who are covered by polices for which we are out of network and they choose to continue their care with our practice due to the high standards of care and service we provide. They tell us they hardly even notice a difference in their out of pocket investment. Our knowledgeable business team can help you with any questions or concerns.

As a service to you, we will file insurance claims for up to 2 policies on your behalf. It is your obligation to provide us with all necessary insurance information and your card. Your insurance policy is a contract between you and the carrier to pay for agreed upon services. We encourage you to become familiar with your plan and the benefits it provides as well as any exclusions or limitations.

We cannot know the details of each plan and are counting on you to do so for your own benefit. Your insurance company is required to provide you with an EOB (explanation of benefits) which explains what we billed on your behalf and what they did or did not pay as a result. We advise you to read these and reach out to your insurance company should you have questions about your coverage.

The bill you receive from NIM, Inc, DBA Aurora Dental Care is an agreement between you and NIM, Inc, DBA Aurora Dental Care. You are fully responsible for all charges to your account regardless of your dental insurance coverage.

Billing & Payment Policies: We will do our best to maximize your insurance reimbursement, but ultimately you, the patient, are responsible for any fees or payments that remain. As a courtesy to you, we will ***estimate*** your charges and any out of pocket investment in your care and this ***estimated*** amount will be due at each visit. Any ***estimated*** charges are just that, an ***estimate*** and are in no way a guarantee that there will not be a future balance on your account. If you do not have insurance, payment

in full will be expected at each visit. For your convenience we accept cash, Visa, MasterCard and Care Credit.

If you choose not fulfill your financial agreement to our practice within 90 days, it will be considered in everyone's best interest to refer your account to a collections agency. Your account may be assessed a $25.00 late fee. We urge you to avoid this scenario by keeping in communication with our office. We do not want to negatively affect your credit status. If your account is delinquent, we will consider you to be out of relationship with our office and your appointments may be cancelled.

In the event your insurance unexpectedly pays for a service that you paid for, causing a credit on your account, you will be issued a refund. If the credit on your account is less than $20.00 we will leave it on your account for future treatment unless you request we send it to you which we will happily do.

Fees for Services: Fees for services are based on our costs and are carefully evaluated. We consider factors such as, level of professional attainment, supplies, time, administrative costs and much more. We are proud of our fees. Please understand that due to the nature of your care, it can be challenging to provide precise financial information.

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 one of our providers. You may call Dr. Nick on his cell phone at **(907) 841-1880** if you are having a dental emergency.

Acceptance of Responsibility: I understand that I am financially responsible for all charges to my account regardless of insurance. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to NIM, Inc. DBA Aurora Dental Care, any benefits applicable for services rendered. I know it is my responsibility to notify NIM, Inc. DBA Aurora Dental Care, of any changes to my account including insurance coverage, mailing address, phone number, emergency contact etc. I give permission to contact me via phone, email, fax, regular mail or other means as deemed necessary to provide optimal care or to collect any account balances. I give permission to answer questions about my credit experience with your office. I understand you have the option to report my account status to any credit reporting agency such as a credit bureau. I understand that if this account is submitted to an attorney or collection agency, if we litigate in court, or if my past-due status is reported to a credit reporting agency, any treatment received at your office may become a matter of public record.

I have read and understand the Office Policies listed above and I agree to comply. I have had the opportunity to ask any questions related to the financial aspect of my treatment at NIM, Inc, Dba Aurora Dental Care. I certify to the best of my knowledge that all information I have provided is accurate and true and I agree to the contents of this document.

Patient's Printed Name: ________________________________ Date: __________

Patient or Guardian's Signature: ________________________________ Date: __________

Witnessed By: ________________________________ Date: __________