Welcome to Alaska Dental Care!

Brett M. Gardiner, DDS *Kevin J. Parks, DDS

We will strive to provide you with the best possible care. If you have any questions or need assistance, please ask – we're here to help!

We LOVE New Patients! Please send us your friends and co-workers.
By doing to we'll give you $50.00!!

Patient Information

Patient Name _____ *Preferred Name* _____ *o Male o Female*

Mailing Address _____ *Zip Code*_____

Physical Address _____ *Zip Code*_____

DOB _____/_____/_____ *SSN* _____-_____-_____ *Home #* _____ *Cell #* _____

E-mail Address _____*Work #* _____

Please tell us your preferred method of appointment reminders, circle all that apply: Home Work Cell Text Email

*Spouse or Parent Name*_____ *DOB* _____/_____/_____ *SSN* _____-_____-_____

Other Parent Name _____ *DOB* _____/_____/_____ *SSN* _____-_____-_____

*Person to Contact In case of Emergency*_____ *Daytime Ph.#* _____

How did you hear about us? Mailer Internet Friend (name)_____***Other***_____

Insurance Information

*Name of Primary Insurance Company*_____ *Phone #* _____

Employees' Name _____ *DOB* _____/_____/_____ *ID #*_____

Employer's Name _____ *Group #*_____

*Name of Secondary Insurance Company*_____ *Phone #*_____

*Employees' Name*_____ *DOB* _____/_____/_____ *ID#*_____

Employer's Name _____*Group #*_____

Regardless of insurance, patients are ultimately responsible for all charges accrued. We will send claims to your insurance company for all treatment, however, we ask that the insurance company be authorized to pay us directly and you pay your estimated portion at the time of service.

*Signature*_____ *Date*_____

Medical History

Patient's Name _____ *DOB* _____/_____/_____

*Physician's Name*_____ *Date of Last Physical* _____

- *Are you happy with your smile??* *Yes* *No*

  If no, what would you change? _____

- *Have you been seriously ill in the last 5 years?* *Yes* *No*

  If yes, please explain: _____

- *Are you **allergic** to any drugs or substances?* *Yes* *No*

  *If yes, which ones?*_____

- *Are you **taking** any medications, pills, or drugs? (prescription or herbal)* *Yes* *No*

  If yes, please list: _____

- *Have you ever had a bad reaction to a dental injection of local anesthetic?* *Yes* *No*
- *Females, are you pregnant or nursing?* *Yes* *No*
- *Do you, or have you smoked or used smokeless tobacco?* *Yes* *No*

  If yes, how much per day _____ *for how long* _____ *Quit*_____

Please circle if you have had any of the following

High Blood Pressure	*Tuberculosis*	*Anemia*
Low Blood Pressure	*Lung Disease*	*Asthma*
Heart Murmur	*Emphysema*	*Latex Allergy*
Heart Pacemaker	*Liver Disease*	*Bruise Easily*
Artificial Heart Valve (premed Y / N)	*Hepatitis (type ____)*	*Prolonged Bleeding*
Stroke	*AIDS / HIV*	*Epilepsy / Seizures*
Rheumatic Fever	*Kidney Trouble*	*Thyroid Disease*
Bacterial Endocarditis	*Cancer (type _____)*	*Hypoglycemia*
Heart trouble not listed _____	*Chemotherapy / Radiation*	*Arthritis / Gout*
Artificial Joints (Year _____ premed Y / N)	*Diabetes*	*Osteoporosis*
Pain in jaw joint	*Frequent Headaches*	*Drug/Alcohol Dependency*

Have you had any medical condition or serious illness not circled above? *Yes* *No*

*If yes, please explain:*_____

Patient's Initials _____ ***Today's Date*** _____ ***Initial BP / Pulse*** _____ _____ ***Staff Initials*** _____