PATIENT INFORMATION

Today's Date:____________________________________
Patient Name:____________________________________
Preferred Name:__________________________________
Drivers License #:________________________________
Social Security #:_________________________________
Address:____
City:____
State:_________________ Zip Code:_______________
Circle One: Male Female
Age: __________
Birth Date:__________ /______________ /___________
Circle One: Married Widowed Single
Minor Separated Divorced
Patient Employer/School:__________________________
Occupation:_____________________________________
Employer/School Address:_________________________
____
Employer/School Phone:___________________________
Birth Date: ___________ /_____________ /___________
Spouse's Name:__________________________________
Spouse's Employer:_______________________________
Who may we thank for referring you?
____

CONTACT INFORMATION

Home Phone:_____________________________________
Work Phone:_____________________________________
Cell Phone:______________________________________
Spouse's Work Phone:_____________________________
Email:____

IN CASE OF EMERGENCY, CONTACT:

Best time and place to reach you?__________________
Relationship:____________________________________
Home Phone:_____________________________________
Cell Phone:______________________________________

DENTAL INSURANCE

Person responsible for this account:________________________
Insurance Company:_______________________________________
Group Name:____________________________ Group #______________
Subscriber's Name:____
Birth Date:______ /_______ /______ Social Security #:______________
Relationship to Patient:____________________________________

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with __________________________ and assign directly to Dr. Phillip Johnson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

Dr. Johnson may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent/Guardian or Personal Representative

____
Print Name of Patient, Parent/Guardian or Personal Representative

________________________ ____________
Relationship to Patient *Date*

DENTAL HISTORY

Date of last dental cleaning:_________________________________
Date of last dental x-rays:__________________________________
Former Dentist:____
City, State:________________________ Phone:___________________
*Is there anything about the appearance of your smile that you would like to change?*____
Fearful of dental treatment? (scale of 1-10): _________________________
Have you had an unfavorable dental experience in the past? _______________
Do you have difficulty getting numb and/or reaction to anesthetic? __________

DENTAL HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Bad breath	☐ Yes	☐ No	Jaw pain or tenderness	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips of mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Broken fillings	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No	Broken/chipped tooth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Cigarette/pipe/cigar smoking	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No	Sores/growths in mouth	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No	Foreign objects	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Grinding Teeth	☐ Yes	☐ No			
Gums swollen, tender or bleeding	☐ Yes	☐ No	Food caught between teeth frequently	☐ Yes	☐ No			

HEALTH HISTORY

Physician's Name:____ Date of last visit:____

Have you ever taken any of the group of drugs collective referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
ADD/ADHD	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Allergy - Acetaminophen	☐ Yes	☐ No	Chemo	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergy - Aspirin/Ibuprofen	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Allergy - Codeine	☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No	Osteoporosis/Osteopenia	☐ Yes	☐ No
Allergy - Erythromycin	☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No	*On Bisphosphonates*	☐ Yes	☐ No
Allergy - Latex	☐ Yes	☐ No	Cough/persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Allergy - Local Anesthetic	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Allergy - Penicillin/Amoxicillin	☐ Yes	☐ No	Diabetes (HbA1c=________)	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Allergy - Sulfa	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergy - Tetracycline	☐ Yes	☐ No	Endocarditis	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy - Vicodin	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy - Other______________	☐ Yes	☐ No	Fainting/dizziness	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Allergy - Metal	☐ Yes	☐ No	**FEMALE:** *Pregnant*	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
(Nickel, Gold, Silver)			*Nursing*	☐ Yes	☐ No	Smoking	☐ Yes	☐ No
High or Low Blood Pressure	☐ Yes	☐ No	Artificial Heart Valve or repaired heart defect	☐ Yes	☐ No	Stroke (taking blood thinners)	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Swollen feet/ankles	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Head injuries	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	*Cardia Stent in past 6 mos*	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Hepatitis Type: ___________	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Anemia or Blood Disorder	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

LIST ALL MEDICATIONS, SUPPLEMENTS, AND/OR VITAMINS TAKEN WITHIN THE LAST 2 YEARS:

DRUG	PURPOSE	DRUG	PURPOSE
________________________	____________________________	__________________	__________________________________
________________________	____________________________	__________________	__________________________________
________________________	____________________________	__________________	__________________________________

Welcome to our office! Thank you for choosing us for your dental care needs. Our goal is to help you maintain your dental health, while providing excellent customer service.

OFFICE HOURS:

Tuesday 8:00 AM - 5:00 PM
Wednesday 8:00 AM - 5:00 PM
Thursday 8:00 AM - 3:00 PM
Friday 8:00 AM - 2:00 PM

FEES, INSURANCE, CARE CREDIT, WELLS FARGO HEALTH ADVANTAGE AND BILLING:

Your insurance policy is a contract between you and your insurance company. Although our doctor may be contracted with your insurance company, our relationship is with you - not the insurance company. As your dental provider, we will file your claim for you. Your insurance carrier may not approve or reimburse your dental services due to usual and customary rates, benefit exclusions, coverage limits and lack of authorization or dental necessity. **We try to give our best estimate based on the information we have been given by your plan**. It is **never** a guarantee of payment. We will not become involved in disputes between you and your insurance carrier. **Any remaining balance after insurance sends payment is solely the responsibility of the policyholder/patient.** We do not file secondary dental insurance. We do not offer in-house financing. We offer CareCredit or Wells Fargo Health Advantage which have extended payment options, some of which are interest free.

MISSED OR RESCHEDULED APPOINTMENTS WITHOUT PROPER NOTICE:

Our office does everything possible to remain on schedule. If you are more than 15 minutes late, we may need to reschedule your appointment to another day or time. **We require 24 hours notice when changing, rescheduling or canceling an appointment. Failure to abide by this policy will result in a charge of $50 per hour, per appointment.** This charge will be applied to your account and must be paid before any other appointments can be made. Because we understand that emergencies happen, the implementation of this fee will be evaluated on a case-by-case basis.

______________________________	______________________________	__________
Signature	*Print Name*	*Date*

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

You may refuse to sign this acknowledgement

I, ____ , have received a copy of this office's Notice of Privacy Practices.

____ ____ ______________

Signature *Print Name* *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 acknowledgement
- ☐ As emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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