BRIAN D. JOHNSON, D.M.D.

Patient Health Record

The following information is requested to assist the Doctor in administering the proper dental service. Please answer the questions to the best of your ability, and use the additional space for answers requiring clarification or any additional information. Thank you for your cooperation.

NAME (Last) (First) (Middle)

HOME ADDRESS

City State Zip

PHONE (Home) (Business)

DATE OF BIRTH SEX SS# MARITAL STATUS

EMPLOYER ADDRESS:

SPOUSE'S NAME EMPLOYER BUS. PHONE:

DENTAL INSURANCE COMPANY AND PHONE #

REFERRED BY _____ REASON FOR VISIT: _____

Emergency information - Name, Address and Telephone No. of an individual we can call. _____

MEDICAL HEALTH

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of your physician _____

Last complete physical? _____

Are you presently under the care of a physician? Yes ☐ No ☐ If so, for what reason? _____

Are you taking any medication now? Yes ☐ No ☐ If Yes, please list all Medications. _____

Are you allergic to: Antibiotics ☐ Codeine ☐ Aspirin ☐ Local Anesthetics ☐ Other ☐ _____

Have you ever been hospitalized? If so give name of hospital, reason and dates. _____

Have you had any blood transfusions? _____ Yes ☐ No ☐

Are you currently trying to modify your weight? _____ Yes ☐ No ☐ Do you take any medications to help in weight reduction? _____ Yes ☐ No ☐

Do you smoke cigarettes? Yes ☐ No ☐ How many per day? _____

Do you consume alcohol on a daily basis? ..... Yes ☐ No ☐

Have you experienced any recent weight change? ..... Yes ☐ No ☐

Women: Are you pregnant? Yes ☐ No ☐ How long? _____

Do you experience pre-menstrual syndrome? ..... Yes ☐ No ☐

Do you have a history of cold sores, fever blisters or canker sores? ..... Yes ☐ No ☐

Have you ever used drugs for recreational purposes? ..... Yes ☐ No ☐

Please complete back page

Do you have or have ever been informed that you had any of the following:

Chest Pains ..... Yes ☐ No ☐
Heart Disease ..... Yes ☐ No ☐
Rheumatic Fever ..... Yes ☐ No ☐
Congenital Heart Defects ..... Yes ☐ No ☐
Heart Murmur ..... Yes ☐ No ☐
Postural Hypotension (fainting spells) ..... Yes ☐ No ☐
Hypertension (High Blood Pressure) ..... Yes ☐ No ☐
Kidney Problems ..... Yes ☐ No ☐
Stroke ..... Yes ☐ No ☐
Thyroid Problems ..... Yes ☐ No ☐
Hormonal Problems ..... Yes ☐ No ☐
Ulcers ..... Yes ☐ No ☐
Tuberculosis or Lung Disease ..... Yes ☐ No ☐
Diabetes ..... Yes ☐ No ☐
Epilepsy or Seizures ..... Yes ☐ No ☐
Anemia ..... Yes ☐ No ☐
Cancer or Leukemia ..... Yes ☐ No ☐

Psychiatric Problems ..... Yes ☐ No ☐
Sickle Cell Disease ..... Yes ☐ No ☐
Glaucoma ..... Yes ☐ No ☐
Prosthetic Valves or Joints ..... Yes ☐ No ☐
Bruise Easily ..... Yes ☐ No ☐
Asthma or Hay Fever ..... Yes ☐ No ☐
Allergies or Hives ..... Yes ☐ No ☐
Sinus Trouble ..... Yes ☐ No ☐
Arthritis ..... Yes ☐ No ☐
Excessive Urination and/or Thirst ..... Yes ☐ No ☐
Persistent Cough ..... Yes ☐ No ☐
Prolonged Bleeding Problems ..... Yes ☐ No ☐
Sexually Transmitted Disease: (Gonorrhea, Syphilis, Genital Herpes) .. Yes ☐ No ☐
AIDS ..... Yes ☐ No ☐
Prolonged Sore Throat ..... Yes ☐ No ☐
Fatigue ..... Yes ☐ No ☐
Hepatitis (A, B, or C) ..... Yes ☐ No ☐

DENTAL HEALTH

When was your last dental visit? _____ Dentist Name _____

Have you ever had any serious problems associated with previous dental treatment? Yes ☐ No ☐

If yes, explain: _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you routinely use a mouth rinse? Yes ☐ No ☐ How often? _____ Do you experience dry mouth (Xerostomia)? ..... Yes ☐ No ☐

Do your gums feel tender or swollen? ..... Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain or sensitivity? ..... Yes ☐ No ☐

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? ..... Yes ☐ No ☐

Are any of your teeth sensitive to air or during chewing? ..... Yes ☐ No ☐

What texture brush do you use? Soft ☐ Medium ☐ Hard ☐

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐ Does food catch between your teeth? ..... Yes ☐ No ☐

Do you feel your teeth are affecting your health in any way? ..... Yes ☐ No ☐

Do you clench or grind your teeth while sleeping or during the day? ..... Yes ☐ No ☐

Do your facial muscles ever feel tired? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Are you apprehensive (nervous) about your dental treatment? .... Yes ☐ No ☐ If yes - have you had: Nitrous Oxide ☐ Medication prior to treatment ☐

Please add anything you feel is important: _____

DR JOHNSON OFFICE PAYMENT POLICY

1) All charges must be paid at the time of treatment unless previous arrangements have been made.
2) This office always charges a fee for sterilization in order to abide by OSHA regulations.
3) We accept VISA, MASTERCARD, DISCOVER, PERSONAL CHECKS AND CASH.
4) There will be a charge for any appointments cancelled with less than 48 hours notice.

CONSENT:

I have read and will abide by the office policies of Dr Johnson and further will allow them permission to discuss my conditions with my physician and to request medical information from him.

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

PATIENT SIGNATURE (PARENT OF CHILD) _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

Brian D. Johnson, D.M.D., P.C.

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IMPORTANT INFORMATION ABOUT DENTAL INSURANCE

Dental insurance is playing a larger and larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you, regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits, but to reemphasize; we have no relationship with or responsibility to your insurance company.

FACT 1: Dental insurance is not meant to be a "pay all", it is only meant to be an aid.

FACT 2: Many plans tell their insured that they will be covered up to 100%. This figure is based on usual and customary charges. Most of our fees fall within those parameters, however there may be procedures that our fees are greater than UCR. Unless stipulated by a PPO plan, it is your responsibility to pay the difference.

Fact 3: Each plan utilized in our office pays different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We do our very best to make as close an estimation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

Fact 4: Many routine dental services are not covered by insurance carriers. We make our recommendations based on your dental needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will file insurance at no cost to you. We will do all that we can to assure you of your optimum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of your plan.

_____I authorize the release of all necessary information

_____ I authorize payment of benefits directly to the provider

_____I have read this form and agree to be financially responsible for all fees regardless of insurance payment.

Signature_____ Date_____

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Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anestheic agaents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient signature_____ Date_____
Parent/responsible party signature_____

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FINANCIAL AGREEMENT

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other dentists in the area.

Our policy requires payment at the time of service for office visits and procedures. If you are a PPO member in which we participate, your portion is required at the time of service.

Cosmetic services are not covered by insurance. Payment for all cosmetic services is payable at the time of service.

We ask for the courtesy of 24-48 hours notice to cancel an appointment. This allows patients with emergencies the opportunity to be worked into that time slot. Appointments broken with less than 24 hours notice are subject to charge. This charge will be determined by the amount of time originally scheduled. Insurance will not cover this charge.

For your convenience, we are pleased to accept American Express, Visa, MasterCard, and Discover. We also offer the convenience of paying your balance online through our website. There will be a $25 charge for all returned checks.

If you have any questions about our financial policy or insurance reimbursement, please feel free to discuss them with the office manager.

I have read and understand my financial responsibilities under this policy.

Patient signature_____ Date_____