

**Patient Information- Adult**



Patient Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

Male Female Minor Single Married MI (preferred Name) Separated Divorced Widowed

Address: \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Driver's License: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_  
State Number

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
(Cell): \_\_\_\_\_ Where do you prefer to receive Calls? Home Work Cell

**Person To Contact In Case Of Emergency** (outside of immediate family/household) Name \_\_\_\_\_

Relationship \_\_\_\_\_ Wk # \_\_\_\_\_ Home Phone \_\_\_\_\_

**Referral by:** Internet Insurance List Val Pak Radio Phonebook  
Drive By Candy Buy Back Commercial Friend \_\_\_\_\_

**Insurance Information**

**Primary**

Name of Insured: \_\_\_\_\_ Is insured a patient?  yes  no  
Last First MI

Insured's birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_ ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Company and address \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_ Wk# \_\_\_\_\_

**Additional Insurance**

Name of Insured: \_\_\_\_\_ Is insured a patient?  yes  no  
Last First MI

Insured's birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_ ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Company and address \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_ Wk# \_\_\_\_\_

**Financial Agreement:**

1. Payment is expected at the time of treatment.
2. Insured patients are expected to pay their deductible and percent co-payment at the time of treatment.
3. Authorize a credit bureau report to be obtained when deemed necessary.
4. Grant permission to you or your assignee to telephone me at my home or at my workplace to discuss matters related to my treatment or account.
5. In the event of default in the payments, a service charge of 13/4% per month (21% annual rate) on the unpaid balance will be assessed. I/We agree to pay all attorney's, court costs, filing fees, and all collection costs. Up to 40% of the amount owing may be assessed by any collection agency retained to pursue the matter. Minimum monthly finance charge is \$2.00. A \$15.00 charge will be assessed on any returned checks.

**Insurance Authorization and Release:**

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. Dr. Johnson's office only estimates the insurance co-payment. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also assume responsibility to inform Dr. Johnson's office of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize release of any information, including diagnosis and records of any treatments or examinations rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or companies or any other agency necessary for the collection of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable by me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled. This authorization is considered to be effective for present and all future insurance claims.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my care.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

HIV/AIDS	Excessive Bleeding	Kidney Disease	Stroke
Allergies _____	Fainting	Liver Disease	Tuberculosis
_____	Glaucoma	Mental Disorders	Tumors
Anemia	Growths	Nervous Disorders	Ulcers
Arthritis	Hay Fever	Pacemaker	Venereal Disease
Artificial Joints	Head Injuries	Pregnancy	Latex Allergy
Asthma	Heart Disease	Due Date: _____	Penicillin Allergy
Blood Disease	Heart Murmur	Radiation Treatment	OTHER: _____
Cancer	Hepatitis	Respiratory Problems	_____
Diabetes	High blood Pressure	Rheumatism	_____
Dizziness	Jaundice	Sinus Problems	
Epilepsy		Stomach Problems	

- Have you ever had any complications following dental treatment? Yes No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician? Yes No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification? Yes No  
If yes, please explain: \_\_\_\_\_
- Do you take any medication, including birth control pills? Yes No  
Please specify the name and purpose of medications: \_\_\_\_\_
- Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? Yes No
- Have you ever had an unusual reaction or are you allergic to any of the following drugs: Codeine \_\_\_\_; Aspirin \_\_\_\_;  
Acetaminophen \_\_\_\_; Ibuprofen \_\_\_\_; Barbiturates \_\_\_\_; Sulfa Drugs \_\_\_\_; Other \_\_\_\_\_
- Have you ever taken Phen-Fen or similar appetite suppressants? Yes No  
If yes, have you seen your physician or cardiologist for a cardiac evaluation? Yes No
- Have you ever used or are you now using (tobacco/alcohol)? Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

**Signature of patient, parent or guardian**

**INFORMED CONSENT**

I authorize Dr. Johnson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Notice of privacy practices can be obtained from the receptionist.

Thank you for filling out this form completely.

The information you have provided will help us serve your dental healthcare needs more effectively and efficiently.

If you have any questions at anytime, please ask-we are always happy to help.

Date: \_\_\_\_\_

**Signature of patient, parent or guardian**