Johnson Dental Partners

MEDICAL AND PATIENT HISTORY

PATIENT INFORMATION:

Date: _____

Patient's Name _____ Male/Female _____

Married/Single _____ Preferred Name/Title: _____

Address (Street, City, State, Zip) _____

Home Phone _____ Mobile Phone _____

Birthdate _____ Social Security # _____

Whom may we thank for referring you to our office? _____

Employer _____ Occupation _____

No. Years Employed _____

PARENT/GUARDIAN INFORMATION (IF MINOR):

Name _____

Address (Street, City, State, Zip) _____

Home Phone _____ Mobile Phone _____

Birthdate _____ Social Security # _____

Relationship to Patient _____

Employer _____ Occupation _____

No. Years Employed _____

SPOUSE'S INFORMATION:

Name _____ Mobile Phone _____

Birthdate _____ Social Security # _____

Employer _____ Occupation _____

No. Years Employed _____

EMERGENCY INFORMATION:

Name of nearest relative not living with you _____ Relationship _____

Address (Street, City, State, Zip) _____

Home Phone _____ Mobile Phone _____

MEDICAL HISTORY

In order to protect your health it is important that you answer the following:

Name and adrresss of Family Physician: _____

Are you presently under the care of a physician? _____ Date of last complete physical _____

Have you been hospitalized in the last two (2) years? _____ If so, please explain:_____

_____

List all medication you are presently taking (attach addt'l sheet if necessary) _____

_____

Have you ever had an allergic reaction to any drugs or medication? Please list _____

_____

Have you ever had any of the following? Please indicate:

Yes	No		Yes	No	
____	____	Allergy to Latex	____	____	Tuberculosis
____	____	Rheumatic Fever	____	____	Respiratory Disease
____	____	Heart Trouble	____	____	Nervous condition
____	____	Heart Murmur (MVP)	____	____	Diabetes
____	____	Artificial Joints	____	____	Sinus Problems
____	____	Implanted Plates/Pins	____	____	Thyroid Disorder
____	____	High Blood Pressure	____	____	Kidney Trouble
____	____	Low Blood Pressure	____	____	Psychiatric Care
____	____	Pacemaker	____	____	Stroke
____	____	Anemia or Blood Disorder	____	____	Hemophilia
____	____	Asthma or Hay Fever	____	____	AIDS/HIV positive
____	____	Radiation Treatment	____	____	Excessive Bleeding
____	____	Convulsions or Epilepsy	____	____	Other/List _____
____	____	Bruxism (Night Grinding)			_____
____	____	Hepatitis or Liver Disease			_____
____	____	Arthritis			_____
____	____	Cancer (type) _____			

If female, are you pregnant? No _____ Yes _____, what month? _____

Do you smoke? No _____ Yes _____, how many packs per day? _____

Do you chew tobacco? No _____ Yes _____, how often? _____

Signature (Parent's Signature if Minor): _____Date: _____

Updates (dates and initials) _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

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PATIENT DENTAL HISTORY

PATIENT INFORMATION:

Date: _____

Name _____

What is the purpose of your visit? _____

Are any or all of your teeth sensitive to: ☐ Heat ☐ Hot ☐ Sweets ☐ Biting or pressure

Yes	No	
____	____	Do you feel any teeth that are loose?
____	____	Have you noticed any tenderness or swelling in your gums?
____	____	Do you avoid either side while chewing or brushing?
____	____	Do your gums bleed during or after brushing?
____	____	Have you had periodontal treatments?
____	____	Have you ever been told you have periodontal disease?
____	____	Are you aware that you may be clenching or grinding your teeth? Day or Night? (circle)
____	____	Do your jaws feel tired, especially in the morning?
____	____	Do you have pain in front of or above your ears?
____	____	Do you have all or most of your natural teeth?
____	____	Have missing teeth been replaced?
____	____	If not replaced, are you concerned about the possible outcome?
____	____	Have you has a complete series of x-rays (16-20 films) within the last 3 years?
____	____	Have you had your teeth cleaned and examined regularly?
____	____	Have you ever been instructed regarding proper home care of you teeth?
____	____	How often do you brush your teeth? _____
____	____	Do you use dental floss? How Often? _____
____	____	Do you have a fear of dentistry?

Please explain how you feel about your teeth? Are you happy with your smile?

_____

_____

_____

Is there any other information that you think we should know?

_____

_____

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CONSENT FOR TREATMENT, PAYMENT AND PRACTICE OPERATIONS

Welcome to Johnson Dental, we are glad you have chosen our office as your provider and would like to provide you with the best possible dental care and service. To better help you become familiar with our office; we would like to address areas we feel are most important.

1) I give this practice my consent to use or disclose my protected health information to carry out my treatment and to obtain payment from insurance companies.
2) I have been informed that I may review the practice's NOTICE OF PRIVACY PRACTICES (for a more complete description of uses and disclosures) before signing consent.
3) I understand that this practice has a right to change their privacy practices and that I may retain any revised notices at the practice.
4) I understand that I have the right to request a restriction of how my protected health information is used. However; I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restriction (s).
5) I understand that I may revoke this consent at any time, by making a request in writing. Such a request will not apply to any information already used or disclosed prior to request.
6) Appointments. We take great pride in reserving your appointment in advance, and it is extremely important that you to keep your scheduled appointment. If an emergency arises, we ask that you give our office a **48 hour notice** to avoid a cancellation or no-show fee.
7) Our hygiene department starts treating patients at the age of 2 years old, but Dr Johnson does not begin to do restorative work until the age of 6 years old, however, if your child does need restorative work, we will be glad to provide you with the name of a pediatric dentist.
8) Billing. It is our office policy that payment is expected at the time service is rendered. As a courtesy to you, we will bill your primary insurance company and accept their payments along with your co-payments at each appointment. However, the ultimate investment for services lies strictly with the patient. Any discrepancy between our estimation of your insurance benefits and the actual payments is between you and your insurance company, if the insurances company has not paid their portion within 30 days, we ask that the payment be made in full by the patient. We do accept ALL major credit cards; we also accept Care Credit as a payment option.

Patient Name _____

Signature _____ Date: _____

If signed by patient representative, state relationship to patient: _____

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