NEW PATIENT FORMS

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Full Name________________________________ Social Security #________________________________

Birth Date________________________________ Age____________________ ☐ Male ☐ Female

Address____

City____ State _____ Zip________________________________

Full Time Student ☐ Yes ☐ No School Name____

Employer____ Occupation________________________________

Previous Dentist__________________________________ Previous Dentist Phone________________________

Current Physician_________________________________ Current Physician Phone_______________________

Whom may we thank for referring you?

2) TELEPHONE & EMAIL

Home Phone_____________________ Work Phone_____________________ Cell Phone_____________________

Email____

In the event of an emergency, who should we contact? Name____

Relationship__________________________ Home Phone________________ Work Phone_________________

3) RESPONSIBLE PARTY

Who is responsible for this patient?

Full Name____ Social Security #__________________________

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Date____ Age__________________ ☐ Male ☐ Female

Address____

City____ State ______ Zip________________________________

Employer____ Occupation________________________________

Home Phone______________________________________ Work Phone________________________________

Medical History

PATIENT NAME ____ Birth Date ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	Yes	No	If yes, please explain: ______________________
Have you been hospitalized or had a major operation?	Yes	No	If yes, please explain: ______________________
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ______________________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	______________________
Are you on a special diet?	Yes	No	______________________
Do you use tobacco?	Yes	No	______________________
Do you use controlled substances?	Yes	No	______________________

Women: Are you :

Pregnant/Trying to get pregnant? Yes No   Taking oral contraceptives? Yes No   Nursing? Yes No

Are you allergic to any of the following?

Aspirin   Penicillin   Codeine   Local Anesthetics   Acrylic   Metal   Latex   Sulfa drugs

Other:____

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes, please explain:________________________

Comments:____

____

____

DENTAL HISTORY

1. Reason for Visit / Main Concern? ____

2. Are there other conditions of which we should be aware? YES _____NO_____

If yes, please specify:____

3. When did you last visit a dentist? ____________What treatment was performed?____

____

5. Was the treatment completed? YES_____NO_____.   Were dental x-rays taken? YES_____NO_____

7. Did you have a cleaning? YES_____ NO_____

8. Have you had gum (periodontal) treatment? YES_____ NO_____

9. Have you ever had prolonged bleeding after an extraction? YES _____ NO_____

If yes, please specify:____

10. Have you had any problems with past dental treatment? YES_____ NO_____

If yes, please specify:____

____

11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES____NO___

If yes, please specify:____

12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES_____ NO_______

If yes, please specify:____

13. Do your gums bleed easily?   YES_____ NO______

14. Do you feel you have bad breath? YES_____NO_____

15. Are your teeth sensitive to hot or cold? YES_____ NO____

16. Would you like your teeth whiter? YES_____NO_____

17. Are you happy with your smile?   YES______ NO______

If no, please explain:____

Permission to Use Photograph

Subject: Before and After Dental Treatment Photograph

Location: Johnson Family Dentistry, Powder Springs, GA.

In connection with the dental services, which I am receiving from Dr. Crystal Johnson DDS, I agree and consent to allow any photographs taken before, during and after completion of my dental treatments to be used for research, education, public relations, patient counseling or other purposes.

I further agree and consent that the photographs relating to my dental care may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals or dental books.

Signature ________________________________Printed name ____

Address _________________________________Date ____

Office and Financial Policies
(Updated August 8, 2017)

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dentistry in a caring and enjoyable atmosphere. Below you will find information on our appointment and financial guidelines which we require that you read and sign prior to beginning any treatment. Please feel free to ask one of our staff members any questions you may have.

Appointment Policy

The doctor and team members spend extensive amounts of time preparing for your visit. Late, broken and missed appointments create scheduling problems for our team as well as other patients. Our office strives to see every patient at their appointed time. In order for us to do that, it is important that you arrive on time. **If you are late by 15 minutes or more, your appointment may be subject to being rescheduled and a broken appointment fee will be applied.** If you need to reschedule your appointment we ask that you call us as soon as possible so that we may offer the appointment time to another patient that may be waiting to get in**. Any missed or broken appointments without 48 hours' notice will incur a $35 cancellation fee.**

Insurance Claims

We file all claims forms electronically, provide postage for special claims and track the claims as courtesy to our patients. Our office will accept assignment for primary and secondary insurance. We make every effort to accurately estimate your benefits prior to your appointment, however, most insurance companies do not give an accurate quote until the actual claim is received and processed. **The benefits we are given by the insurance company are an ESTIMATE ONLY and not a guarantee of payment.**

On the day of your appointment, you will be asked to pay the portion that we estimate the insurance company will not pay based on your coverage. We will then file the claim, and the insurance portion will be paid directly to our office. If the insurance check is sent directly to you, then you will be asked to pay the entire portion at the time of treatment. **Any amount not covered by your insurance will be your responsibility. If there is a difference between your portion and the insurance company's payment, we will send you a statement for the balance.** Our office will file your insurance claim a maximum of two (2) times per appointment. If the claim is not paid by your insurance carrier within 60 days, the balance will automatically be transferred to your account and further insurance appeal becomes your responsibility. Please be aware that there is a possibility that some of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental insurance policy.

Payment Options

Our goal is to help remove the financial barriers so our patients can receive the dental care they need and desire. We are more than happy to discuss our fees and how they relate to your particular situation. We accept cash, checks, Visa, MasterCard, Discover, and American Express. We even offer 3rd party treatment financing through Care Credit and Lending Club. It is against our policy to accept post dated checks or hold checks for any period of time. Please note that any account balances that reach 90 days past due will be turned over for collection. There will be a $30 service charge for all returned checks.

Thank you for reading and understanding our office policies.

Name____Date___________________

Signature____

Johnson Family Dentistry, LLC

*** You May Refuse to Sign This Acknowledgment***

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

Print Name:____

Signature:____

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 the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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