WELCOME

Patient Information

Date ________________

Name (Last) ______________________ (First) ______________ (MI) ____ ❐ Male ❐ Female

Address (include P.O. Box) ______________________________

City ______________________ State ____________ Zip Code ____________

E-Mail Address ______________________ Social Security No. ______________

Date of Birth ___/___/___ ❐ Married ❐ Widowed ❐ Single ❐ Separated ❐ Divorced ❐ Minor

Phone Numbers

Home (___) ______________ Work (___) ______________ Ext. Best time to call: AM-PM, anytime, leave message.

Cell (___) ______________ Pager (___) ____________ Fax (___) __________ Spouse's work (___) ________

Preferred method of contact: ❐ Home ❐ Cell ❐ Work ❐ E-mail ❐ Fax

Emergency contact:

Name ______________________ Phone number (_____) ______________

Occupation ______________________________

Patient Employer/School ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

__Dental__ Insurance Information

Primary *Dental Insurance*:

Insurance Company Name and Address: ______________________________

Group No.: ______________________________

Name of Policy Holder: ______________________________
Last First MI

Policy Holder's Birth Date: ______________ ID #/Social Security ______________ Other ID ____________

Policy Holder's Address: ______________________________
Street City State Zip Code

Policy Holder's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to policy holder: ❐ Self ❐ Spouse ❐ Child ❐ Other

Secondary *Dental Insurance*:

Insurance Company Name and Address: ______________________________

Group No.: ______________________________

Name of Policy Holder: ______________________________
Last First MI

Policy Holder's Birth Date: ______________ ID #/Social Security ______________ Other ID ____________

Policy Holder's Address: ______________________________
Street City State Zip Code

Policy Holder's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to policy holder: ❐ Self ❐ Spouse ❐ Child ❐ Other

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Dental History

Reason for today's visit: ______________________________

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

Bad Breath ❒ Yes ❒ No	Grinding teeth ❒ Yes ❒ No	Periodontal treatment ❒ Yes ❒ No
Bleeding gums ❒ Yes ❒ No	Gums swollen or tender ❒ Yes ❒ No	Sensitivity to cold ❒ Yes ❒ No
Blisters on lips or mouth ❒ Yes ❒ No	Jaw pain or tiredness ❒ Yes ❒ No	Sensitivity to heat ❒ Yes ❒ No
Broken fillings ❒ Yes ❒ No	Lip or cheek biting ❒ Yes ❒ No	Sensitivity to sweets ❒ Yes ❒ No
Burning feeling on tongue ❒ Yes ❒ No	Loose teeth ❒ Yes ❒ No	Sensitivity when biting ❒ Yes ❒ No
Clicking or popping jaw ❒ Yes ❒ No	Mouth breathing ❒ Yes ❒ No	Sores in your mouth ❒ Yes ❒ No
Dry Mouth ❒ Yes ❒ No	Mouth pain, brushing ❒ Yes ❒ No	Tobacco use ❒ Yes ❒ No
Fingernail biting ❒ Yes ❒ No	Orthodontic treatment ❒ Yes ❒ No	
Food traps between teeth ❒ Yes ❒ No	Pain around ear ❒ Yes ❒ No	

Health History

Physician's Name ______________________________ Date of last visit ______________________________

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

AIDS/HIV ❒ Yes ❒ No	Headaches ❒ Yes ❒ No	Stroke ❒ Yes ❒ No
Anemia ❒ Yes ❒ No	Heart Murmur ❒ Yes ❒ No	Thyroid Problems ❒ Yes ❒ No
Arthritis ❒ Yes ❒ No	Heart Problems ❒ Yes ❒ No	Tuberculosis ❒ Yes ❒ No
Heart Valves ❒ Yes ❒ No	Hepatitis Type ________ ❒ Yes ❒ No	Ulcer ❒ Yes ❒ No
Artificial Joints ❒ Yes ❒ No	High Blood Pressure ❒ Yes ❒ No	Venereal Disease ❒ Yes ❒ No
Asthma ❒ Yes ❒ No	High Cholesterol ❒ Yes ❒ No	
Bleeding abnormality ❒ Yes ❒ No	Jaundice ❒ Yes ❒ No	
Blood thinners ❒ Yes ❒ No	Kidney Disease ❒ Yes ❒ No	**Women:**
Cancer ❒ Yes ❒ No	Liver Disease ❒ Yes ❒ No	Are you pregnant? ❒ Yes ❒ No
Chemical Dependency ❒ Yes ❒ No	Low Blood Pressure ❒ Yes ❒ No	Birth control pills? ❒ Yes ❒ No
Chemotherapy ❒ Yes ❒ No	Mitral Valve Prolapse ❒ Yes ❒ No	Are you nursing? ❒ Yes ❒ No
Diabetes ❒ Yes ❒ No	Pacemaker ❒ Yes ❒ No	
Emphysema ❒ Yes ❒ No	Psychiatric Care ❒ Yes ❒ No	**Premedication** ❒ Yes ❒ No
Epilepsy ❒ Yes ❒ No	Respiratory Disease ❒ Yes ❒ No	**Reason** ______________________
Fainting or dizziness ❒ Yes ❒ No	Rheumatic Fever ❒ Yes ❒ No	______________________
GERD ❒ Yes ❒ No	Scarlet Fever ❒ Yes ❒ No	
Glaucoma ❒ Yes ❒ No	Sinus Trouble ❒ Yes ❒ No	

Medications/Allergies (Attach list if necessary)

Medication/dosage	Reason for medication
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergies

- ❒ Penicillin
- ❒ Asprin
- ❒ Codeine
- ❒ Latex
- ❒ Sulfa
- ❒ Other ____________

This information is accurate to the best of my knowledge. I authorize the use of diagnostic and treatment information such as dental models, photographs or any other materials to consult with other health care practitioners or for teaching and scientific purposes. I consent to the risks of dental treatment.

____ Date ____/____/____

Patient (or responsible party)

Jean D. Johnson, D.D.S., F.A.G.D, LLC
2201 Fifth Street Hollow Road, Suite 2
Bloomsburg, PA 17815

PATIENT POLICIES

We truly appreciate you entrusting us with your dental health. As an office and staff, we pride ourselves on delivering the highest quality care and level of service to our patients in a friendly and caring environment. We need your help. To achieve our goals we have outlined specific appointment and financial policies. It is important that you know and understand these so we can serve you and all our patients to the best of our ability.

Appointment Policy:

An appointment in our office is reserved specifically for you and the doctor or hygienist. Some dental practices use a "double booking" appointment system. While this practice virtually insures that every appointment time has at least one patient, a benefit to the practice, it generally means that patients receive half the attention, a disservice to the patient. Imagine what it would be like going for a haircut, having your car repaired, or employing a contractor to work on your house, when every five minutes he's leaving you to take care of someone else he's scheduled in the time you rightfully thought was yours. To give full attention to you, we offer two primary and costly benefits. We do not "double book" our schedule. We also deliberately leave room in our schedule for "emergency" patients who have urgent needs. Leaving this open space will create minimal impact on patients who have reserved an appointment. In these tight economic times, these practice, which we view as a mission of this practice, can only work with your cooperation and responsibility in the following manner:

- If you are unable to make your reserved time, we ask you to call our office during business hours at least 2 business days (48 hours) in advance. We will send you reminders to help facilitate this process.
- A "no-show" appointment is simply one where the patient does not call our office or leave a message in accordance with the above guideline.
- On the first no-show appointment you will be charged a cancellation fee of $45. This fee is a fraction of what it costs us to provide you quality care. We feel committed to pay our professionals for the time they are at work as opposed to the people who show for their appointments. We would hope all employers would treat their employees the same.
- After two no-show appointments, you may be dismissed from the practice. It simply may be the best arrangement for both parties.
- If you are running late for an appointment, we ask that you please call us to keep us informed. This will allow our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for service. Our scheduling coordinator will work with you as needed.

Financial Policy:

OVER

One of the most complicated forms, besides the IRS 1040, can be an insurance form. As a service to our patients, we gladly submit your insurance claims to your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Benefits are different between employers and, at times, between employees of the same company. We cannot know everyone's benefits, but will be happy to help you understand yours. However, it is the responsibility of the patient to notify this office of any changes to name, address, phone number and employer as well as to know or have access to the benefits of your insurance policy. If insurance has changed, it is the responsibility of the patient to present the new insurance card and information at the time of visit. We all hate surprises!! Since your dental insurance is a benefit you've earned from your employer, please familiarize yourself with your benefits. You should be aware of all charges not covered by your insurance, which includes co-pays and deductibles, because ***payment is required at the time of service for charges not covered by your insurance company.***

I agree that I will be responsible to pay for any portion of the charges not covered by my insurance. If I fail to pay the outstanding balance within thirty (30) days of the due date, I understand that my obligation may be referred to a third-party collection agency and that I will be responsible for any collection fees, interest, and other expenses necessary to collect on my account, including court costs, should legal action be instituted against me.

I have read, understand and agree to the above cancellation and financial policies.

______________________________	___________________________	__________
Patient Signature	Printed Name	Date