

PATIENT INFORMATION

Last Name _____ First _____ MI _____ Preferred _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____ - ____ - ____ Soc. Sec# ____ - ____ - ____ Email _____
Home Phone _____ Cell Phone _____ Other Phone _____

Patient's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse/Parent's Name _____ Employer _____ Phone _____
Student Status: () Full Time () Part Time Name of School/ College _____
Who may we thank for referring you? _____ Phone _____
Nearest Friend/Relative not living with you _____ Phone _____
Emergency Contact _____ Relationship _____ Phone _____

RESPONSIBLE PARTY, IF DIFFERENT FROM ABOVE

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____ - ____ - ____ Soc. Sec# ____ - ____ - ____ Email _____
Home Phone _____ Cell Phone _____ Other Phone _____

INSURANCE INFORMATION:

PLEASE PROVIDE INSURANCE CARD TO FRONT DESK

Insurance Company: _____ Name of Employer: _____
Insured's Name: _____ D.O.B. ____ - ____ - ____ ID # _____
Relationship to Patient: (Circle One) SELF SPOUSE PARENT/GUARDIAN

DO YOU HAVE ADDITIONAL INSURANCE? Yes or No **IF YES, PLEASE CONTINUE:**

Insurance Company: _____ Name of Employer: _____
Insured's Name: _____ D.O.B. ____ - ____ - ____ ID # _____
Relationship to Patient: (Circle One) SELF SPOUSE PARENT/GUARDIAN

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for the payment of all services rendered on my behalf or on my dependents behalf. I agree to pay all collection fees. A 50% fee will be added to the total balance and I am responsible for any attorney's fees.

SIGNATURE _____ **DATE** _____

DENTAL INFORMATION

How long has it been since your last dental visit? _____

What was done at that time? _____

Are you currently having any specific problems? _____

How would you describe your present dental health? GOOD FAIR POOR

Are you satisfied with the appearance of your teeth? _____

Do your gums bleed while brushing or flossing? _____

Have you had any head, neck or jaw injuries? _____

Have you experienced any problems in your jaw? _____

Do you have frequent headaches? _____

Have you had any orthodontic treatment? _____

Have you had any unusual effects from previous dental treatment? _____

Describe _____

MEDICAL INFORMATION

Physician _____ Phone _____ Last Physical _____

Are you taking any medications? _____ please list: _____

Are you allergic to local anesthetics or any medications? _____

Please list: _____

Have you been hospitalized in the last 5 years? _____ Why? _____

Women: Might you be pregnant? YES NO
Are you nursing? YES NO
Are you taking birth control pills? YES NO

Do you consume alcoholic beverages? _____ Smoke/Chew tobacco? _____

Are there any other health problems we need to know about? _____

The above questions have been accurately answered. I understand that providing incorrect information may be dangerous to my health.

SIGNATURE _____ **DATE** _____

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

PLEASE CIRCLE:

Heart Murmur

Arthritis

Heart Disease

ADD/ADHD

Asthma

Liver Disease

High Blood Pressure

Low Blood Pressure

Radiation Treatment

Tuberculosis

Kidney Problems

Diabetes

Venereal Disease

Epilepsy/ Seizure

Hepatitis

Mitral Valve Prolapse

Rheumatic Fever

Positive HIV Test

Ulcers

Psychiatric Care

Office Policy

In an effort to provide our patients with quality, affordable dental treatment, please be prepared to pay your deductible and your estimated portion at each appointment. We accept personal checks, cash and all major credit/debit cards. You are financially responsible for any charges incurred regardless of whether or not your insurance covers your dental services. We bill your insurance company as a courtesy as long as we have complete insurance information. _____ (initials)

YOU MUST REALIZE HOWEVER THAT:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
_____ (initials)
- Dental insurance is not meant to be a pay-all: it is only meant to be an aid. Many routine dental services are not covered by dental insurance at all. If you should have any questions regarding your coverage, you should contact your HR department regarding the details of the plan. It is your responsibility to know your insurance coverage. _____ (initials)
- Many plans tell you, you will be covered “100%”. In spite of what you are told we have found that most plans only cover approximately 80% of an average fee. It has been our experience that some insurance companies tell their clients that “fees are above the usual and customary” rather than saying, “The benefits are low”. _____ (initials)
- Most insurance companies do not “require” preauthorization, therefore, if you would like to receive a preauthorization please inform us before your dental work is done. We do not always receive preauthorizations back in a timely matter; it is suggested to follow up with your insurance on any pending preauthorizations.
_____ (initials)

We must emphasize that as dental care providers, our relationship is with you NOT your insurance company.

If your account remains unpaid it will be sent to collections and 50% of the total balance will be added to your account and you will be responsible for any attorney fees. There is a \$25.00 fee for returned checks. _____ (initials)

Parents, we cannot treat minor children without parental consent. If you are unable to accompany your children to their appointment, please notify our office staff. Also, please plan to either send payment with your children or make prior financial arrangements with our front office staff. We will happily furnish you with a receipt showing your payment.

_____ (initials)

DIVORCE OR CUSTODY CASES: The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

_____ (initials)

We make every effort to contact our patients to confirm appointments. Please notify us as soon as possible regarding any changes in contact numbers, address or insurance.

_____ (initials)

Please give us a 24-hr notice if you cannot make your appointment. Failed appointments will be assessed a \$50 no-show fee. _____ (initials)

Any x-rays taken by this office becomes the official dental record of this office. Records can be transferred to another dental office but cannot be released to an individual.

_____ (initials)

(Patients or guardian signature)

(Date)

Curtis D. Johnson, D.D.S. PC
726 N. Greenfield Rd. #126
Gilbert, AZ 85234
480-813-8890

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

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

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of privacy Practice, 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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