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 ever taken a bisphosphonate medication (e.g. Fosamax)?___________

Have you been hospitalized in the last 5 years? ______ Why? ___________

____

WOMEN: Might you be pregnant? 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? ____

____

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

PLEASE CIRCLE:

Acid Reflux

ADD/ADHD

Arthritis

Asthma

Autoimmune Disease

Bleeding Disorder

Cancer / Chemotherapy

Diabetes

Epilepsy / Seizure

Heart Disease / Attack

Hepatitis A / B / C

High / Low Blood Pressure

Kidney / Liver Disease

Organ Transplant

Positive HIV Test

Psychiatric Care

Radiation Treatment

Tuberculosis

*__Artificial Heart Valve__

*__Congenital Heart Defect__

***Infective Endocarditis**

*__Prosthetic Joint Implant__

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

SIGNATURE ____ **DATE** ____________________

JOHNSON & LARSEN FAMILY DENTISTRY
FINANCIAL POLICY

We are pleased that you selected Johnson & Larsen Family Dentistry for your dental care. In an effort to control rising costs associated with billing, please acknowledge your understanding of the following:

- You understand that you are unconditionally financially responsible for any charges incurred regardless of insurance coverage or payment. ____________**(Initials)**
- For uninsured patients, all fees are due at the time of treatment. You may pay with cash, check, credit card, debit card.
- For patients with dental insurance, the estimated patient portion is due at the time treatment is rendered. We will bill your insurance company as a courtesy for you. Our efforts to collect from your insurance company do not waive your responsibility to pay the charges in the event your insurance company fails to do so. _____________**(Initials)**
- Please be prepared to pay your deductible once per year, plus any co-pays as required by the terms of your contract with your insurance carrier.
- For treatment plans that are greater than $500, a 5% courtesy discount is available when payment is made in full prior to the start of treatment.
- For those who need extended payment arrangements, we offer Care Credit, a healthcare finance plan that offers <u>interest free</u> loans. The front office staff will be able to provide you with the information on the plans that are available and answer any questions regarding payment options. Eligibility for the healthcare finance plan is entirely between you and Care Credit. Despite any agreement or approval between you and Care Credit, you remain responsible for all charges for services rendered.________________**(Initials)**

<u>PLEASE BE AWARE:</u>

- Your insurance coverage is a contract directly between you, your employer (if applicable), and the insurance company. Johnson & Larsen Family Dentistry is not a party to that contract. _____________**(Initials)**
- Dental insurance is not meant to cover all expenses. Your dental insurance is only intended to be a financial aid. Many routine dental services are not covered at all by your insurance. If you have any questions regarding your coverage or benefits, please contact your HR department or your insurance company directly. It is your responsibility to know your insurance coverage. We are willing to assist you with understanding your benefits but we do not assume responsibility for you knowing those benefits. _______**(Initials)**
- Most insurance companies do not "require" preauthorization for treatment. If you would like a preauthorization submitted on your behalf, please inform the front office prior to treatment. Insurance companies, on average, return predeterminations in 6-8 weeks. We strongly recommend you follow up with your insurance company on any pre-authorizations that are pending. Regardless of any preauthorization granted for treatment, you remain responsible for payment of all charges. _____________**(Initials)**
- Insurance companies may tell you that the fees are above "usual and customary" rather than state that their fees are considered low by today's standards. Benefits quoted are not a guarantee of eligibility or benefits. Insurance companies determine eligibility and benefits at the time the claim is received. When claims are paid, insurance companies may pay at a lower percentage than quoted because of alternate benefit clauses built in to your contract, benefits being exhausted for that year, waiting periods, or eligibility at the time the claim is received. You are financially responsible for the balance of any claim not paid by your insurance company._______ _____________**(Initials)**

We are proud to provide the best quality dental care to you and your family. Please remember that as providers for your overall oral health, our relationship is with you and **NOT** with your insurance company.

If there is a balance due after payment by your insurance, or if your insurance refuses to pay, we will send a billing statement in the mail to notify you of the unpaid balance. Payments are due in full within 30 days. Please call the office if you have any questions regarding your bill or payments due. After a reasonable period of time we will turn all unpaid balances over to a collection agency. Outstanding balances will accrue interest of 18% per annum. In addition, you are responsible for any additional collection agency fees (up to 10% per annum of the outstanding balance) plus attorney fees and court costs. _________**(Initials)**

There will be a $35.00 fee for returned checks. We reserve the right to refuse checks from anyone that has a returned check history. _____________**(Initials)**

We make every effort to contact our patients to confirm appointments. Please notify us of any changes to address, phone numbers, or insurance as soon as possible. _______**(Initials)**

We require 24 hour notice if you cannot make your appointment. Failed appointments will be charged a $50 no show fee. ___________**(Initials)**

X-rays and dental records are the property of the dentist and dental office. By law you are entitled to a copy of your records after a written request has been received. A reasonable fee may be charged to the patient for the cost of the duplication of the records.

PARENTS OF MINOR CHILDREN. We cannot treat minor children without parental consent. If you are unable to accompany your child to their appointment please notify our office staff in advance. Please send a signed and dated consent for treatment with your child to the appointment. Please send your payment with your child to the appointment or call the office to make other arrangements prior to the appointment time. We will furnish you with a receipt showing your payment. ________
_______**(Initials)**

DIVORCE OR CUSTODY CASES. The parent or guardian who brings the child into our office is financially responsible for the services rendered regardless of (i) any provisions to the contrary in the divorce or custody decree, (ii) who has physical custody, or (iii) who is the subscriber on the insurance.
_______**(Initials)**

I have received a copy of the financial policy set forth by Johnson & Larsen Family Dentistry, I have had ample opportunity to ask any questions regarding this policy and those questions have been answered to my satisfaction. ________________**(Initials)**

I understand my financial obligation as a patient of this practice and agree to all the terms and conditions listed. I further understand that this policy may be changed or amended by the office at any time without notice. This policy replaces any previous policy in its entirety.

____ ___________________________
Signature Date

Print Name:____________________________________

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)

____