Patient Information

Date_____

SS/HIC/Patient ID #_____

Patient_____

Address_____

City _____

State _____ Zip_____

E-mail_____

Sex ☐ M ☐ F Age_____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Phone Numbers

Home (____)_____

Work (____)_____ ext_____

Cell (____)_____

Best time and place to reach you _____

In Case of Emergency Contact

(someone who does not live in your household)

Name _____ Relationship_____

Home (____)_____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co _____

Group # _____

Is patient covered by additional insurance? YES NO

Subscribers Name_____

Birthdate_____ SS# _____

Relationship to Patient_____

Insurance Co _____

Group# _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the dentist release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

The above names doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Dental History

Reason for today's visit _____

_____

_____

Former Dentist _____

City/State _____

Date of last visit to a dentist?

_____

Date of last dental x-rays?

_____

Please check the box if you have had any of the following:

Bad Breath..... ☐

Bleeding Gums ..... ☐

Blisters on lips or mouth ..... ☐

Burning sensation on tongue ..... ☐

Chew on one side of mouth..... ☐

Cigarette, pipe, or cigar smoking..... ☐

Clicking or popping jaw ..... ☐

Dry mouth ..... ☐

Fingernail biting ..... ☐

Food collection between teeth ..... ☐

Foreign objects ..... ☐

Grinding teeth ..... ☐

Gums swollen or tender ..... ☐

Jaw pain or tiredness ..... ☐

Lip or cheek biting ..... ☐

Loose teeth or broken fillings ..... ☐

Mouth breathing ..... ☐

Mouth pain, brushing ..... ☐

Orthodontic treatment ..... ☐

Pain around ear ..... ☐

Periodontal treatment ..... ☐

Sensitivity to cold ..... ☐

Sensitivity to heat ..... ☐

Sensitivity to sweets ..... ☐

Sensitivity when biting ..... ☐

Sores or growths in your mouth ..... ☐

How often do you floss? _____

How often do you brush? _____

Medical History

Physicians Name_____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine). YES NO

Please check to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve Prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation tx
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Special diet
- ☐ Stroke
- ☐ Swollen feet or ankles
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Weight loss, unexplained

Do you wear Contact Lenses? YES NO

Women:

Are you pregnant? YES NO Due Date _____ Are You Nursing? YES NO

Taking birth control pills? YES NO

Medications

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name _____ Phone Number _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physical certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Steven R. Johnson, D.D.S.
4322 Ravensworth Road
Annandale, VA 22003

703-256-5870/Phone
703-256-5396/Fax

Financial Responsibility Agreement

Dr. Johnson and associates make every effort to keep the cost of your care down. *Full payment is due at the time of service (i.e. co-pays, deductibles, or full fee). To assist you in making payment we accept cash, checks, Visa, MasterCard, American Express, and Discover.

We are not contracted with all insurance plans but we are happy to file a claim on your behalf. If you have a plan we are not contracted with, we will verify benefits for you and you can decide if you wish to continue with us. Your insurance is a contract between you, your employer, and the insurance company. If you have questions concerning your insurance plan please contact your employer's human resource department or your insurance company directly.

It is the patient's responsibility to know which benefits are covered or not covered by their insurance. The patient/guardian is responsible for all co-payments, deductibles, and fees that are denied or non-covered. Any balance pending with insurance more then 90 days will be due by the patient. If there is an additional balance after the insurance company payment is received the payment is due by the patient within 30 days.

The parent or guardian that brings a minor in for treatment is the financially responsible party. A financial arrangement between individual parental parties does not absolve the parent bringing the minor from their financial obligation to our practice.

If timely payment is not made the services of an attorney, collection agency, or small claims court may be utilized. The cost of additional collection liabilities will be assessed to the patient's account. We have a $34.00 return check fee. Copy of radiographs is a $38.00 fee.

It is the policy of this office for the courtesy of our patients who want Saturday appointments, if a patient Breaks or Cancels a Saturday appointment, with less than 24 Hour Notice the patient will not have the opportunity to schedule a Saturday appointment with our office for one year.
There will be a $35 missed appointment fee if we are not given 24 hours notice to cancel.

Patient's Name (PRINTED):_____

Parent/Guardian Name:_____
(if patient is a minor)

Patient or Parent or Guardian Signature:_____ Date _____