Patient Information

Patient name:_____
Last First MI (Preferred Name)

Gender____ Marital Status:_____ Birth date:_____ Social security #:_____

Mailing Address:_____
Street Apartment #

_____

City State Zip Code Email:

Best contact phone number_____

Employer and address_____

Other family members that come here_____

Whom may we thank for referring you to our office:_____

Billing Information If other than patient information above

Person responsible for account /relationship:_____

Social security #_____D.O.B._____Address:_____

City:_____ State:_____Zip code:_____

Home phone:_____Work_____Cell:_____

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly and mutual understanding between the provider and patient

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. As a courtesy to our patients we will bill your insurance company, providing we have the correct information on file. It is ultimately your responsibility to know your insurance coverage and benefits. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I fully understand I am solely responsible for any and all balances not paid by my insurance company.

Patient signature **Date**

As a COURTESY to our patients we will bill your insurance company, providing we have the correct information on file.

DENTAL Insurance information

Primary Insurance Information (MEMBER)

Name of insured _____
Last First M

Insured's D.Q.B._____SS#_____

Insured's Address_____

Insurance Company_____

Employer_____

Insurance Billing Address_____

_____

Group# ID# Relationship to insured self spouse child other

Secondary Dental Insurance

Primary Insurance Information (MEMBER)

Name of insured _____
Last First MI

Insured's D.O.B._____SS#_____

Insured's Address_____

Insurance Company_____

Employer_____

Insurance Billing Address_____

_____

Group# ID# Relationship to insured self spouse child

PATIENT ACKNOWLEDGMENT OF

NOTICE OF PRIVACY PRACTICES

DATED 2003

AND

RECEIPT OF DENTAL MATERIAL FACT SHEET

DATED MAY 2004

I,_____,

ACKNOWLEDGE INFORMATION IS AVAILABLE FROM

S. SHAUN JOHANSON, DDS

NOTICE OF PRIVACY PRACTICES

AND

DENTAL MATERIAL FACT SHEET

PATIENT SIGNATURE_____

DATE_____

Name_____

MEDICATION LIST

Please list all medications and supplements you are currently taking
(If you have a list of medications we can make a copy)

Medical information **Name** _____ **DATE**_____

If you have a medication list **we can make a copy, or complete medication list.**

Have you ever had or have any of the following? Please circle those that apply

AIDS/HIV
Anemia
Arthritis **type**_____ **Asthma**
Artificial Joints **type**_____ **surgery date**_____**PRE-MEDICATION y n**

Allergic to: Codeine Penicillin Latex Vicodin Other:

Blood disease
Blood thinners **name**_____
Cancer or Tumors **type**_____ **Radiation treatment Y N**
Chemotherapy Y N
Diabetes **type**_____
Epilepsy
Excessive bleeding
Fainting or Dizziness
Glaucoma
GI or ulcers
High blood pressure
Kidney disease
Lung disease
Liver disease or Jaundice or Hepatitis **type**_____
Mental disorders or Nervous disorders

Osteoporosis **Do you take Fosomax or other**

Pregnant **Y N** **due date**_____ **Respiratory problems**
Sinus problems
Stroke
Tuberculosis
Thyroid **Medication**_____

HEART CONDITIONS **(please circle those that apply)**

Heart problems **Mitral valve prolapse** **Pace maker**
Rheumatic fever **Heart murmur**
Do you take PRE-MEDICATION prior to dental treatment for any heart conditions Y N

Do you smoke or chew tobacco? Y N how much?_____ **Have you ever had any complications following dental treatment? Y N**

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

Y N If yes, please explain: _____

Are you now currently under the care of a physician ? Y N

If yes, please explain: _____

Date of your last physical?_____**Name of Physician:** _____ **Do you have any health problems that need further clarification? Y N**

If yes, please explain: _____

*Patient Signature*_____*Date*_____

*RDH/RDA*_____*DR.*_____