JOHNSON FAMILY DENTAL, PLLC

Thank You for Choosing Our Dental Team

Patient Information (Confidential)

Name_____ Date_____

SSN_____ Birth Date_____ Home Phone_____

Address_____ City_____ State____ Zip Code_____

Email Address_____ Cell Phone_____

Check Appropriate: __ Minor __ Single __ Married __ Separated __ Divorced __ Widowed

Patient or Parent/ Guardians Employer_____

Work Phone_____ Business Address_____

City_____ State_____ Zip Code_____

Spouse or Parent/Guardians Name _____ Employer_____

Work Phone _____

Who May We Thank For Referring You?

_____

Emergency Contact Name _____ Phone_____

Responsible Party

Name of Person Responsible for this Account

_____ Relationship to patient_____

Home Phone _____ Cell Phone _____

Address_____

Email ____ _____ Driver's License #_____

Birthdate _____ SSN _____ Financial Institution_____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes___ No ___

For your convenience, we offer the following methods of payment. Please check the option you prefer, Payment in full at each appointment.

Cash___ Personal Check ___ Credit Card ___ VISA ___ MasterCard ___ Discover ___ CareCredit ___

Dental Insurance Information

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ SSN _____ Employer _____

Union or Local # _____ Work Phone _____ Cell Phone_____

Employer Address _____

Insurance Company _____ Policy ID _____

Group #_____ Insurance Phone Number _____

Insurance Mailing Address _____

Do You Have Any Additional Dental Insurance? Yes ___ No ___ If yes, please complete the following

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ SSN _____ Employer _____

Union or Local # _____ Work Phone _____ Cell Phone_____

Employer Address _____

Insurance Company _____ Policy ID _____

Group #_____ Insurance Phone Number _____

Insurance Mailing Address _____

Patient Medical History

Physician Name _____ Phone _____ Date of Last Visit _____

Preferred Pharmacy and Location _____ Phone _____

1. Are you under medical treatment now? Yes ___ NO ___
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes ___ No ___ If yes, please explain
   _____
3. Are you taking any medication(s) including non-prescription medication? Yes ___ No___
   If yes, please list any medications you are taking

_____

_____

4. Have you ever taken Fen-Phen/Redux? Yes___ No___
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes ___ No ___
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?
7. Do you use tobacco? Yes ___ No ___
8. Do you use controlled substances? Yes ___ No ___
9. Do you wear contact lenses? Yes ___ No ___
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes ___ No ___
11. Women Only:
    - Are you pregnant or think you may be pregnant? Yes ___ No ___
    - If yes, how many weeks? _____
    - Are you nursing? Yes___ No ___
    - Are you taking oral contraceptives? Yes___ NO___

12. Are you allergic to or have you had any reactions to the following?

-Local Anesthetics (e.g. Novocain)	Yes ___ No___
-Sulfa Drugs	Yes ___ No ___
-Barbiturates	Yes ___ No ___
-Sedatives	Yes ___ No ___
-Iodine	Yes ___ No ___
-Aspirin	Yes ___ No ___
-Any Metals (e.g. nickel, mercury, etc.)	Yes ___ No___
-Latex Rubber	Yes___ No ___
-Penicillin	Yes___ No ___
-Codeine	Yes___ No ___
-Erythromycin	Yes___ No ___
-Food allergies	Yes___ No ___

If yes, please list

_____

-Other Allergies

_____

_____

13. Do you have, or have you ever had, any of the following? Check all that apply.

__High blood pressure	__Rheumatic Fever
__Heart Attack	__Swollen Ankles

__Fainting/Seizures
__Asthma
__Low blood pressure
__Leukemia
__Diabetes
__Kidney Disease
__AIDS or HIV Infection
__Thyroid Problem
__Heart Disease
__Heart Murmur
__Cardiac Pacemaker
__Angina
__Frequently Tired
__Anemia
__Emphysema
__Cancer
__Arthritis
__Joint Replacement or Implant
__Hepatitis/Jaundice
__Sexually Transmitted Disease
__Stomach troubles/Ulcers
__Chest Pains
__Easily Winded
__Stroke
__Hay Fever/Allergies
__Tuberculosis
__Radiation Therapy
__Glaucoma
__Recent Weight Loss
__Liver Disease
__Heart Trouble
__Respiratory Problems
__Mirtral Valve Prolapse
__Other _____
_____

Patient Dental History

Name Of previous Dentist_____ Date of Last Exam _____
Previous Dentists Location _____

1. Do your gums bleed when flossing?
2. Are your teeth sensitive to hot or cold liquids/Foods? Yes ___ No ___
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ___ No ___
4. Do you feel pain in any of your teeth? Yes ___ No __
5. Do you have any sores or lumps in or near your mouth? Yes ___ No ___
6. Have you ever had any head, neck or jaw injuries? Yes ___ No ___
7. Have you ever experienced any of the following? Yes ___ No ___
   -Clicking
   -Pain (joint, ear, side of face) Yes___ No ___
   -Difficulty in opening or closing Yes ___ No ___
   -Difficulty in chewing Yes ___ No ___
8. Do you have frequent headaches? Yes ___ No ___
9. Do you clench or grind your teeth? Yes ___ No ___
10. Do you bite your lips or cheeks frequently? Yes ___ No ___
11. Have you ever had any difficult extractions in the past? Yes ___ No ___
12. Have you ever had any prolonged bleeding following extractions? Yes ___ No ___
13. Have you had any orthodontic treatment? Yes ___ No ___
14. Do you wear dentures or partials? Yes ___ No___
    -If yes, date of placement? Yes ___ No ___
    _____
15. Have you ever received oral hygiene instructions? Yes___ No ___
16. Do you like your smile? Yes ___ No ___

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor)