Welcome

Thank you for selecting our Dental Health Care team! We strive to provide you with the best possible dental care. To help us provide personalized and comfortable dentistry, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be glad to help.

1 Patient Information

Today's Date ______________________

Name ______________________ Preferred Name ______________________

Address ______________________ City, State, Zip ______________________

Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Birth Date ______________________ Social Security # ________ - ______ - ________

Employer/Occupation ______________________ Driver's License# ______________________

Home Phone # ____________ Work ____________ Cell ____________ Text Reminders Ok? **Y / N**

Email: ______________________ How did you hear about us: ______________________

If minor:

Mother's Name ______________________ Father's Name ______________________

Would you like to be included in our "short call" list to be included in sooner available appointments? **Y / N**

2 Responsible Party (If different from section 1)

Name ______________________ Relationship to Patient ______________________

Address ______________________ City, State, Zip ______________________

Birth Date ______________________ Social Security ______________________

Employer ______________________ Occupation ______________________

Is the responsible party currently a patient? **Y/N**

3 Insurance Information

Employer ______________________ Name of Insured ______________________

Social Security# ________ - ______ - ________ Birth Date ______________________

Member ID ______________________ Relationship to patient ______________________

Primary Insurance Co. ______________________ City, State, Zip ______________________

4 Personal Information

Emergency contact Name: ______________________ (must be someone not living with you)

Relationship: ______________________ Number: ______________________

5 General Release of Information / Assignment of Benefits

I authorize the release of any information to my insurance company that may be required to process my claim. **INITIAL** ______

I authorize the release of any medical information to consulting or referring physicians. **INITIAL** ______

I authorize direct payment of insurance benefits to Dr. Johnson for services rendered to myself or my dependents. **INITIAL** ______

I authorize treatment by Dr. Johnson and staff. **INITIAL** ______

I consent to the taking of photo / imaging to document my dental condition. **INITIAL** ______

6 Financial Responsibility & Agreement

Our **fees** are meant to be reasonable and competitive; we will be happy to discuss them with you. Please don't hesitate to ask about the cost of a service before it is performed.
Our **collection policy** is a necessary part of assuring the financial resources needed to maintain quality medical services for our patients. In order to establish optimal relations with our patients and avoid potential misunderstanding and confusion regarding our payment policies, our staff is available to inform you of the financial payment policies of the office.

We require payment at the time of service if insurance does not cover any portion of your visit, or if your deductible has not been met. All copayments are required at the time of service.

If you are visiting us on an emergency basis, we require your payment in full at the time of the appointment. If your payment results in overpayment because of subsequent insurance payment, it will be refunded promptly.

INSURANCE: WE WILL, AS A COURTESY TO YOU, BILL YOUR INSURANCE — IF YOU PROVIDE US WITH CURRENT INFORMATION. This is done with the understanding that you remain totally responsible for your charges regardless of your insurance coverage. Because we file your insurance for you does not mean that we accept your company's payment as"payment in full" unless we have a contract with your company. Even though you may have an insurance claim pending, you will receive a statement for the outstanding balance of your account. We cannot accept responsibility for collecting insurance claims 60 days after the date of service, or for negotiating a disputed claim. However, we will do all we can to help you secure your payment.
We will look to you for full payment if your insurance has not been paid within 60 days of service. WE DO NOT HAVE ANY CONTROL OVER YOUR INSURANCE COMPANY'S INTERPRETATION OF THEIR RESPONSIBILITY TO PAY YOUR BILL. OUR AGREEMENT IS WITH YOU, THE PATIENT.

ACKNOWLEDGEMENT OF OUR INSURANCE POLICY: .... **INITIAL** ______

I personally guarantee and accept responsibility for all medical charges incurred by myself or my dependents regardless of any insurance coverage I may or may not have. This includes but is not limited to:
- -expired insurance or loss of eligibility
- -work related injury (we must have prior authorization to bill your employer)
- -cosmetic services
- -services deemed "not medically necessary" or "not covered" by my insurance company
- -any balance that my insurance company has not paid in 60 days .... **INITIAL** ______

The appointment times we reserve are exclusively for you. If you cannot make your appointment, please give 48hrs notice. Accounts over 30 days old are subject to a finance charge. There is also a $25 charge for all returned checks.

Signature ______________________________ **Date** ______________________________
(This signature indicates that I have read, understand, and authorized all above items.)

Thank you for filling out this form completely. The information you have provided will help us serve your dental HealthCare needs more effectively and efficiently. If you have any questions at any time, please ask.
We are always happy to help!

Medical History

NAME ______________________ BIRTH DATE ____________ TODAY'S DATE ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of the entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

MH:

1. Are you currently under the care of a physician? ____ YES___ NO___
   (If yes, please list what you are being treated for and by whom?) ____
2. Have you ever had a tumor or cancer? ____ YES___ NO___
   (If yes, please list what type of cancer, when it was diagnosed, where it was located and how it was treated) ____
   ____
3. Do you have high or low blood pressure?(If yes, circle the one that may apply.) ____ YES___ NO___
4. Have you ever had a heart attack? (If yes, please provide dates.) ____ YES___ NO___
5. Do you have a pacemaker? (If yes, when was it placed?) ____ YES___ NO___
6. Have you ever had heart surgery? (If yes, when and why?) ____ YES___ NO___
7. Do you take anything to thin your blood? (i.e. Aspirin, Warfarin, Plavix) ____ YES___ NO___
8. Have you ever suffered from chest pains or angina? ____ YES___ NO___
   (If yes, do you carry Nitroglycerin tabs with you?) ____ YES___ NO___
9. Have you ever had a stroke? (If yes, when?) ____ YES___ NO___
10. Do you have diabetes? ____ YES___ NO___
    (If yes, are you controlled by Insulin, pills, diet, or nothing? Please circle)
    (If yes, do you test your blood sugar daily?) ____ YES___ NO___
11. Have you ever had a liver condition such as jaundice, hepatitis, or cirrhosis? ____ YES___ NO___
    (If yes, please circle those that may apply and what caused illness) (If Hepatitis: A, B, C, D, or E)
12. Have you ever been diagnosed with Emphysema or Chronic Obstructive Pulmonary Disease? (If yes, please circle which one)_YES___ NO___
13. Do you have sleep apnea? ____ YES___ NO___
    (If yes, do you wear a CPAP? Does it cover your nose, mouth, or both) ____
14. Do you have asthma? (If yes, have you been hospitalized for it or do you use an inhaler? Please list) ____ YES___ NO___
15. Have you ever been diagnosed with Tuberculosis? (If yes, please provide the year.) ____ YES___ NO___
16. Do you have osteoporosis? ____ YES___ NO___
17. Have you ever taken any medication for osteoporosis? (If yes, what?) ____ YES___ NO___
18. Do you have ringing in your ears or loss of hearing? (If yes, circle the one that my apply) ____ YES___ NO___
19. Have you ever been diagnosed with HIV or AIDS or any other sexually transmitted disease? (If yes, please circle one)____ YES___ NO___
20. Have you ever had a joint replacement? (If yes, please provide location and date) ____ YES___ NO___
21. Have you ever been diagnosed with Hyperthyroidism or Hypothyroidism? (If yes, please circle one) ____ YES___ NO___
22. Have you ever had a seizure or epilepsy? ____ YES___ NO___
23. Do you have Cataracts or Glaucoma? (If yes, please circle those that may apply) ____ YES___ NO___
24. Have you ever been diagnosed with fibromyalgia? ____ YES___ NO___

For Women

25. Are you pregnant? ____ YES___ NO___
    (If yes, when is your due date?) ____
26. Are you nursing? ____ YES___ NO___
27. Are you taking birth control pills? ____ YES___ NO___

HOSPITALIZATIONS

28. Have you ever been hospitalized? ____ YES___ NO___
    (If yes, when and what for?) ____
29. Have you had a head, neck or jaw injury? (If yes, when?) ____ YES___ NO___

Medical History - continued (page 2)

MEDICATIONS

30. Presently, are you taking any medication? This includes over the counter, herbs, vitamins, or prescription. _________________ YES___ NO___
    (If yes, please list all medications and milligrams of the same.) ____

    ____

ALLERGIES

31. Are you allergic to, or have you reacted to, any of the following medications:
    Local Anesthetics **Penicillin** **Amoxicillin** **Sulfa Drugs** **Barbiturates** **Sedatives** **Sleeping pills**
    Aspirin **Codeine** **Other narcotics** **Avocado** **Banana** **Other (please list)** ______________________________

SOCIAL HISTORY

32. Do you smoke? ____ YES___ NO___
    (If yes, please provide the approximate number of packs per day_____ and how many years? _____)
33. Do you chew tobacco? (If yes, for how long?) ____ YES___ NO___
34. Do you drink alcoholic beverages? (If yes, approximately how many drinks per week?) __________________ YES___ NO___

FAMILY HISTORY

35. Does anyone in your family have a history of diabetes? _________________________________ YES___ NO___
    (If yes, whom?)____
36. Does anyone in your family have a history of heart disease? ______________________________ YES___ NO___
    (If yes, whom?)____

Dental History

S: 1. What is the reason for you visit today? ____

HPI: 2. When was your last dental visit?____

D: 3. What was the reason for that visit?____

4. What are your dental goals? ____
5. How often do you brush your teeth? ____
6. How often do you floss or water pik your teeth?____
7. Do you see blood when you brush or floss?____
8. Are your teeth sensitive to: (please circle) **Hot** **Cold** **Sweet** **Sour** **Brushing** **Air**
9. Does food tend to get caught between your teeth? ________________________________ YES___ NO___
   If specific area please describe location ______________________________________
10. Do you have TMJ? ____ YES___ NO___ NOT SURE___
11. Have you experienced any of the following? (please circle) **Clicking in jaw joint** **Pain in the jaw joint** **Pain in ears**
12. Have you had any of the following:
    Braces, retainers or Invisalign ____ YES___ NO___
    Gum treatment ____ YES___ NO___
    Oral Surgery____ YES___ NO___
    Night Guard ____ YES___ NO___
13. Do you have dental implants? ____ YES___ NO___
14. Do you have dentures or partials? ____ YES___ NO___
    If yes when were they made? ____
    Is this the only one/ones you have ever worn?____
15. Do you like the appearance of your teeth and smile? YES___ NO___ If no please explain ______________________
16. Are your teeth all in alignment (straight)? YES___ NO___ If no, is that something you would like to correct? _____________ YES___ NO___
17. Are there old fillings or dental work you don't like looking at? _______________________________ YES___ NO___
18. In my past dental experience I have been: (please circle)
    Comfortable **Afraid of needles** **Anxious** **In Pain** **Confused about treatment** **Confused about insurance/financial responsibility**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. Further, by signing below, I authorize Dr. Johnson and her staff to render treatment, and if applicable, provide my insurance company with required information to process my dental claim.

Signature of Patient or Legal Guardian ________________________________ Date ________________

Acknowledgement of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgement

Office Copy

I, X_________________ , have received a copy of Dr. L. Michelle Johnson DDS Notice of Privacy Practices.

X____

Please Print Name

X____

Signature (If under 18 years Parent must sign)

X____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)

____

____

____

Patient Copy

L. Michelle Johnson D.D.S., P.C.

Notice of Privacy Practices

This notice describes how health information about you may be used
and disclosed and how you can get access to this information.
The privacy of your health information is important to us.
Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect August 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that your are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patients Rights

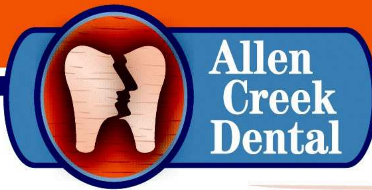
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting this office and requesting this specific form. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the beginning of this Notice. If you request copies, we will charge you $0.25 for each page, $ 15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact our office for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.



Michelle Johnson DDS

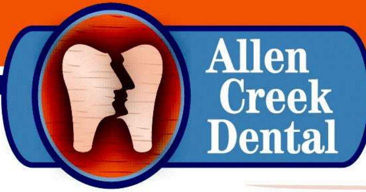
1002 Ramsey Ave. • Grants Pass, OR 97527 • Ph. 541.476.2200 • Fax 541.956.0329
www.allencreekdental.com • Email: info@allencreekdental.com

Permission to Disclose Health Information

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list the individuals below who have your permission to share your health information.

Name	Relationship to Patient	Conditions of Access

Signature of Patient **Date**



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I,______________________________________, request that my dental records be
Name and Date of birth
released to:

To:	From:
______________________________	______________________________
Dental Office	Dental Office
______________________________	______________________________
Phone	Phone
______________________________	______________________________
Fax	Fax

______________________________	____________________
Signature	Date