Referred by: _____ Today's Date: _____

DR. COREY I. JOHNSON

PERSONAL INFORMATION

Patient Name: _____ _____ _____
Last First M.I.

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ ❑ Male ❑ Female

Mailing Address: _____City _____ State _____ Zip _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____ Spouse's Name: _____

What is your preferred method of contact? ❑ Home ❑ Work ❑ Cell ❑ Email

Parent/Guardian name (if patient is a minor): _____ _____
Mother Father

Employer (list parent/guardian's employer if patient is a minor): _____

Employer's Address: _____ City _____ State _____ Zip _____

Do you have dental insurance? ❑ Yes ❑ No If yes, please present insurance card.

Insured's Name: _____ Insured's Employer: _____

Insured's Date of Birth: _____/_____/_____ Insured's SSN: _____-_____-_____

In the event of an emergency, who should we contact? _____

Relation: _____ Home Phone: (_____)_____ Work Phone: (_____)_____

Who is ultimately responsible for this account? _____

MEDICAL HISTORY

Describe your general health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Physician's Name: _____ Office Phone: (_____)_____

Are you required to pre-medicate (with antibiotics) for dental appointments? ❑ Yes ❑ No ❑ Not Sure

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list: _____

_____

Are you allergic to any of the following?

❑ Aspirin ❑ Codeine ❑ Erythromycin ❑ Dental Anesthetic ❑ Latex ❑ Penicillin ❑ Percodan

❑ Other, please list: _____

Have you ever had any of the following?

❑ Anemia	❑ Diabetes	❑ Hepatitis	❑ Prosthetic Valves, Joints, or Implants
❑ Arthritis	❑ Epilepsy/Seizures	❑ High Blood Pressure	❑ Rheumatic Fever
❑ Asthma	❑ Glaucoma	❑ HIV/AIDS	❑ Stroke
❑ Blood Disorder	❑ Heart Attack/Heart Problems	❑ Kidney Problems	❑ Tuberculosis
❑ Cancer	❑ Heart Murmur	❑ Mitral Valve Prolapse	❑ Ulcers

Do you have any disease, condition, or problem not listed above that you think we should know about?

_____

Do you use tobacco? ❑ Yes ❑ No If yes, how much? _____

Women: Are you pregnant? ❑ Yes ❑ No If yes, how long? _____ Are you nursing? ❑ Yes ❑ No

To the best of my knowledge, all of the above information is true and correct. If there are any changes, I will advise the doctor. I fully understand that payment in full is expected at the time services are rendered, unless other arrangements have been authorized in advance by the business manager.

_____ _____
Signature of Patient or Responsible Party Date

DR. COREY I. JOHNSON

We are complimented that you have chosen to partner with us for your dental care. Please read the following statements carefully. We are committed to making your dental care and financial responsibilities as clear and as positive an experience as possible. We invite you to ask any questions or voice concerns regarding your care and financial obligations prior to any treatment. We believe the best dental health services are based on a friendly, mutual understanding between provider and patient.

Consent for General Dental Procedures:

- I understand that I have the right to accept or deny dental treatment recommended by my dentist or hygienist. Prior to consenting to treatment, I will carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.
- I authorize Corey I. Johnson, DDS to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary to make a thorough diagnosis of my dental needs.
- I authorize Corey I. Johnson, DDS to perform all recommended treatment mutually agreed upon by the treating dentist and me.

Financial Policy:

Please understand that payment for services is considered part of your treatment. We have adopted a simple financial policy for all of our patients. Please read, ask any questions, and sign this policy prior to any treatment.

- It is your responsibility to know your insurance plan's benefits prior to any treatment.
- You are fully responsible for all fees charged by this office regardless of your insurance coverage.
- Full payment is due at the time of service for your dental investment.
- Our team can assist you by filing your insurance claim as a courtesy to you. By signing this document, you authorize us to submit all necessary information to your insurance company to facilitate the payment of a claim. If you do not pay in full the day of service, you are authorizing us to accept the assignment of benefit from your insurance company.
- Pending insurance payments over 90 days will become your responsibility.
- 18% annually will be charged to accounts 90 days or greater. I understand that in the event my account is sent to a collection agent, I am responsible for all additional costs including late fees, collection agency fees, court costs, interest and fines.
- Divorced parents of patients should understand that the adult who signs the minor child into our practice on the day of service is responsible for payment. Parents are responsible to communicate between themselves regarding treatment and payment issues.

Thank you for taking responsibility for your dental health and financial obligations.

_____

Printed Patient Name:

_____ _____

Signature of Patient/Parent/Guardian: Date: