JOHNSON FAMILY Dentistry
Brent A. Johnson DDS

Here's What You Can Expect From Us:

- Dr. Johnson and staff will provide you with friendly, professional, competent service.
- We will gladly take the time to answer any questions you may have.
- When scheduling appointments, we will do our best to accommodate your schedule.
- We will try to reach you 24-48 hours before to confirm your appointment
- The environment will be clean. All equipment is cleaned and sanitized properly.
- Our goal is for each visit to be a rewarding experience for both you and us.
- We promise to provide you the highest quality of care in an environment you feel comfortable

Here Is What We Expect From You:

- Be prompt your appointments.
- You are responsible to be here, even if we aren't able to reach you to confirm the appointment.
- To cancel or reschedule appointments, we require 48 hours' notice, not including weekends.
- If you miss your appointment without giving 48 hours' notice, a $50 no-show fee will be charged to your account.
- Payment is expected at the time of service, unless other arrangements have been made prior to your appointment.
- If you have Insurance, we will gladly process your claim, but we request you pay your estimated portion at the time of service.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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Welcome to Our Office!

PATIENT INFORMATION

Patient Name: _____ SS# _____ Date: _____
Home Phone: ( )_____ Cell Phone: ( )_____ Email Address: _____
Birthdate: _____ Age: _____ Sex: ( ) Male ( ) Female
Address: _____ City: _____ State: _____ Zip: _____
Physician's Name: _____ Address: _____
Patient's Guardian: _____ Relationship: _____
Employer: _____ Work Phone #: ( )_____ Patient's Spouse:_____ SS#_____
Whom My We Thank For Referring You to Us or How Did You Discover Our Office? _____
In Case of Emergency Call: _____
Address: _____ Phone: ( ) _____
Nearest Adult Relative Not Living With You?
Name: _____ Relationship: _____ Phone: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR ACCOUNT – IF DIFFERENT THAN ABOVE

Name: _____ Birthdate _____ Relationship_____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Address: _____ Phone: ( ) _____
Spouse's Name: _____ Birthdate: _____ Address:_____
SS#: _____ Employer: _____ How Long:_____ Work Phone: ( ) _____

INSURANCE INFORMATION

Assignment of Insurance Benefit: I hereby authorize my insurance benefits to be paid directly to Brent A. Johnson D.D.S. I am responsible for services not covered. I authorize the release of any dental information or x-rays necessary to process any claim.

Insurance Name of Carrier: _____ Group #: _____
Address: _____ Phone #: ( ) _____
_____ SS#: _____
Name of Insured: _____ Birth Date: _____
Employer: _____

Name of 2nd Carrier: _____ Group #: _____
Address: _____ Phone: ( ) _____
_____SS#: _____
Name of Insured: _____ Birth Date: _____
Employer: _____

AGREEMENT OF EXTENSION OF CREDIT

Unless Cash is Paid As Services Are Rendered

In accordance with the Federal Truth-In-Lending Act, please be advised of the following policies in connection with the extension of credit. By signing this agreement, the responsibility party agrees to:

1. **PAY** in full each time services are rendered. We accept cash, check, or major credit cards.
2. **PAY** 1.75% per month (21% APR) on any unpaid balance that extends over 30 days, with a minimum of $5.00. Financial arrangements must be made prior to first appointment.
3. Authorize a credit report to be obtained if deemed necessary.
4. In the event that full payment charges incurred in my dental care is not made, I agree to pay all costs of collections, including a Collection Agency Commission of up to 45%, plus all collection/court costs, reasonable attorneys' fees if delinquent balance is placed with a collection agency or attorney. I also agree to submit myself to the jurisdiction of the courts of Utah County, Utah.

Signature: **X**_____ Date: _____

Please Read and Sign the Back of This Form

PATIENT'S NAME: _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Brent A. Johnson, D.D.S and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including risk of substantial and serious, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: **X**_____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ Date: _____

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Date of Last physical examination at your medical doctor's office, approximately: _____

Please Circle Yes or No

1. Yes No Have you been under the care of a physician in the past 2 years? _____
2. Yes No Have you had a recent illness or surgery? _____
3. Yes No Have you ever been hospitalized? _____
4. Yes No Are you pregnant? _____

Have You Ever Had Or Do You Have:

5. Yes No Heart trouble or heart surgery? _____
6. Yes No Pains in the chest or shortness of breath? _____
7. Yes No High blood pressure or stroke? _____
8. Yes No Rheumatic fever or heart murmur? _____
9. Yes No Anemia (low blood) or other blood diseases? _____
10. Yes No Thyroid trouble? _____
11. Yes No Jaundice, hepatitis or liver problems? _____
12. Yes No Diabetes or family history of diabetes? _____
13. Yes No Any breathing problems (hay fever, asthma, tuberculosis, sinusitis, emphysema)? _____
14. Yes No Stomach or intestinal problems (ulcer, etc.)? _____
15. Yes No Kidney or bladder problems? _____
16. Yes No Cancer or tumors? _____
17. Yes No Convulsions, seizures, or fainting? _____
18. Yes No Abnormal or prolonged bleeding? _____
19. Yes No Syphilis, gonorrhea, social herpes, or AIDS? _____
20. Yes No Scalp or skin disease? _____
21. Yes No Arthritis, bone disease, joint problems or replacement? _____
22. Yes No Eye problems (glaucoma, retinal repair, etc.)? _____
23. Yes No Use of alcohol, drugs or tobacco? _____
24. Yes No Sudden weight loss or weight gain? _____
25. Yes No Lumps in your neck, armpits, or groin? _____
26. Yes No Recent appearance of discolored areas in your mouth or other parts of your body? _____
27. Yes No Any other medical condition that we should be aware of? _____
28. Yes No Have you ever taken the drug Phen Fen or any like drug?

Are You Taking Now Or Have You Taken Within The Last 2 Years:

29. Yes No Cortisone/Steroids, anti-rejection drugs? _____
30. Yes No Blood thinners (Coumadin, Warfarin, Heparin)? _____
31. Yes No Tranquilizers, sedatives, or pain drugs (aspirin)? _____
32. Yes No Nitroglycerin or other heart medications? _____
33. Yes No Any other medicine or drugs (including birth control pills)?

Have You Ever Had A Reaction Or Allergy (Like Itching, Rash, Or Swelling) To:

34. Yes No Local Anesthetics (Novocaine, Xylocaine, etc.)? _____
35. Yes No Penicillin, sulfa drugs or other antibiotics? _____
36. Yes No Other drugs or medicines? _____
37. Yes No Any kind of metals? _____

Please Complete the Back of This Page

Last dental visit (approximately): _____

What is your immediate dental concern? _____

What is your appropriate weight (for prescription purposes): _____

Please Circle Yes or No

1. Yes No Are you presently in any dental pain? _____
2. Yes No Have you ever had an unfavorable experience in the dental office? _____
3. Yes No Have you ever had orthodontic treatment (braces)? _____
4. Yes No Have you ever had periodontal (gum) treatment? _____
5. Yes No Do you have any growths or swellings in your mouth? _____
   How long have they existed? _____
6. Yes No Is any part of your mouth sensitive to temperature extremes, toothbrushing, or chewing pressure? _____
7. Yes No Does food catch between your teeth more than expected? _____
8. Yes No Do you have any pain or soreness in your head or neck area? _____
9. Yes No Are you aware of clenching or grinding your teeth while you're awake or sleeping? _____
10. Yes No Does your jaw click or pop while eating or yawning? _____
11. Yes No Do you have frequent headaches? _____
12. Yes No Are you dissatisfied with your teeth and their appearance? _____
13. Yes No Do you feel you will eventually wear dentures? _____
14. Yes No Do you want to retain your teeth? _____
15. Yes No Do you frequently consume sweets? _____
16. Yes No Do you snore while sleeping? (not a joke) _____
17. Yes No Have you ever taken any bisphosphonate drugs such as Fosamax, Actonel, Boniva or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drug for metastatic bone cancer? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Patient/Legal Guardian Signature: _____ Date: _____

Updated Medical History, Patient Signature: _____ Date: _____

Updated Medical History, Patient Signature: _____ Date: _____

Doctor's Notes