

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs,
Please fill out this form completely in ink.
If you have any questions or need assistance,
Please ask us - we will be happy to help.

Patient# _____

SS#/SIN _____

Date _____

Home Phone _____

City _____ State _____ Zip _____

Email _____ Cell Phone _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

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 I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local#, _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local#, _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you. Had any allergic reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medications(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen!Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revati, Cialis or Levitra In the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	Yes	No	Other (please list) _____		
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than .3 weeks)?...	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:		
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	Yes	No
Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis/Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles/Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following Problems in your jaw?			14. Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 90 day. Unless previous written financial arrangements are made.

X _____
Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Signature _____</td> <td style="width: 50%; text-align: center;">Date _____</td> </tr> </table>	Signature _____	Date _____
Signature _____	Date _____	

Alan C. Johnson, D.D.S. & Bryan O. Schelin, D.M.D.
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We are often asked about the differences between traditional silver amalgam restorations and the newer state-of-the-art composite restoration, both in terms of treatment considerations and dental plan reimbursement. We hope to answer some of these questions in this letter

Ideally, all dental restorations should be harmless to the pulp and soft tissue, contain no toxic substances that can reach the circulatory system, be free of sensitizing agents, and have no carcinogenic potential. We recognize that both amalgam and composite restorative materials can have positive and negative attributes. As such the material selected for your restoration must be based on your individual needs, not dental plan limitations.

While silver amalgam has been in use for 150 years and has high compressive strength upon setting, it does expand over time. which can cause fractures in tooth structure if the remaining structure is thin. The newer composite resins are 30 to 70% acrylic or polyurethane with the remainder being filler material such as finely ground glass or minerals. They are resistant to abrasion and are less likely than amalgam to expand or contract. The size and location of the restoration as well as the proximity to the pulp, influence which material we recommend.

Careful consideration must be given to your individual clinical needs before recommending the best material for your treatment. In our dental practice, we want our patients to be fully informed and know that Dr. Johnson only uses composite material.

Why do white/composite fillings cost more?

Composite require more care in placement due to a number of different steps involved. Also, composites are cured by a powerful light.. To insure proper curing, composites must be placed incrementally, each stage must be cured. Therefore, it often takes more time and skill to place a composite restoration.

Will my insurance cover tooth-colored fillings? Every patient's dental plan is different. While some plans pay for composite fillings regardless of their location in the mouth, most dental plans define which teeth are eligible for additional reimbursement. Some plans pay higher composite fees only from cuspid to cuspid. There is even a plan that will only pay for amalgam on front teeth!

When a dental plan pays an amalgam fee, instead of the composite fee that was billed, it is not implying that the composite restoration was not the best choice for the patient. It is only saying that the premium paid for the dental plan defines, and often limits the amount the plan will pay for certain services. When a dental plan reduces its payment to a silver filling fee, the difference is the patient's responsibility. Our financial coordinator can provide you with an estimate for the difference in cost. However, it is the patient's responsibility to know their dental benefits.

If you have additional questions regarding the appropriate material for your particular needs after reviewing the information above, please contact our office at (949) 951-1067.
We will be happy to assist you.

_____ Patient Signature _____ Date