Patient Registration

Date _____

Name _____

Single ☐ Married ☐ Divorced ☐ Child ☐

Address _____ SS# _____

City _____ State_____ Zip _____

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

Email address _____

Employer _____

Driver's License Number _____ Date of Birth _____

Nearest Relative _____ Phone _____

Are any of your family patients in our office? _____

Whom may we thank for referring you to us _____

Insurance Information

Insured Person _____

Insured Person's Employer _____

Insured Person's Date of Birth _____ SS# _____

Insurance Company _____

Medical History

Is your general health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are you under the care of a physician? Yes ☐ No ☐

Name of your physician _____

List any surgeries you have had in the last 2 years_____

Do you have or have you had any of the following diseases or problems?

	YES	NO
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Artificial Heart Valve	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Congenital Heart Problems	☐	☐
Heart Attack	☐	☐

	YES	NO
Allergies or Sinus Trouble	☐	☐
Excessive Bleeding	☐	☐
Stomach Ulcer	☐	☐
Breathing Difficulty	☐	☐
Persistent Cough	☐	☐
Dry Mouth	☐	☐
Cold Sores or Fever Blisters	☐	☐

	YES	NO
Tuberculosis	☐	☐
Liver Disease or Hepatitis	☐	☐
Jaundice	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐

	YES	NO
Cancer or Tumor	☐	☐
Radiation Treatment	☐	☐
Blood Transfusion	☐	☐
HIV Infection or AIDS	☐	☐
Seizure Disorders	☐	☐
Psychiatric Problems	☐	☐

Please complete the back side of this form.

Thank you!

Medications

Please list any medications you are taking

Are you allergic to any of the following:

	YES	NO
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Aspirin	☐	☐
Codeine/Narcotics	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Local Anesthetics ("Novocain")	☐	☐
Metals or Jewelry	☐	☐
Any Other Allergies	☐	☐

Please explain below.

Explanations:

Have You Had	YES	NO
Serious trouble associated with dental treatment	☐	☐
X-ray treatment for a tumor or condition of the head or neck	☐	☐
Occupational contact with X-rays or other radiation	☐	☐
Frequent Headaches	☐	☐
Tired or Sore Jaws or Sore Teeth	☐	☐

Are you wearing or using

Removable Dental Appliances (Partial or Complete Denture)	☐	☐

If so, how old are the appliances? _____

Women

Are you pregnant or do you suspect you may be pregnant?	☐	☐
Are you nursing	☐	☐

What is your main concern about your teeth?

_____

_____

We reserve your appointment time ESPECIALLY FOR YOU. We do not "over-book". We make every possible effort to stay on schedule and to avoid any waiting on the part of our patients. Therefore, a $50.00 charge will be automatically charged to your account for appointments not changed at least 24 hours in advance.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of hi/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby place my signature on file and authorize that my insurance forms be filed for legitimate services by Johnson Family Dentistry or their employees.

_____

Signature of Patient

_____

Signature of Dentist

JOHNSON FAMILY DENTISTRY
Patient Financial Arrangements and Dental Insurance

Patient Name:_____

Insurance:
We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefit. The responsible party is expected to present the patient's insurance card at the initial visit and thereafter when insurance changes occur.

You must realize, however, that

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services, which are not covered.

We must emphasize that as dental care providers, our relationship is with you –not your insurance company. While the filing of insurance claims is a convenience that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Self –pay accounts:
Self-pay accounts are patients who are covered by insurance plans with whom the practice does not participate. For patients without an insurance card on file or at the time of service or have not met their deductible, payment is due at the time services are rendered. We accept cash, checks, Visa and Mastercard.

Extended payment arrangements:
In certain circumstances, extended payment arrangements may be made with the business office. Selected payment plans are available through Care Credit, a third party payer.

Divorce cases:
In cases of divorce, the parent bringing the patient in for care is responsible for the insurance deductible and the balance insurance does not cover at the time of service. The practice does not get involved with divorce specifics.

Returned checks:
There are charges for returned checks as well as additional collection fees and interest charges of 1.5% for balances older than 90 days.

Broken appointments:
There may also be a charge for broken appointments and appointments cancelled with very short notice. There will be no charge for appointments, which are changed at least 48 hours prior to your appointment time, during regular office hours. Your appointment is reserved exclusively for you and we appreciate you arriving on time.

Please do not hesitate to ask us if you have any questions regarding your treatment or any uncertainty regarding insurance coverage.

I have read and understand the above information.

_____

Signature

JOHNSON FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I acknowledge that I have received a copy of Dental Health Professional's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Please list the names of your family members who are patients of our practice:

_____

_____

Please return this form to:

Johnson Family Dentistry, 1951 South Alafaya Trail, Orlando, Florida 32828