Robert W. Johnson DMD

Welcome to Our Office!

Patient Registration

Who may we thank for sending you to us?__Friend __Relative: Their Name: _____

Or did you find us in the Phone Book? If so which one?:_____Internet:__ Newspaper Ad _____

Patient Name: _____

Social Security # _____ Date of Birth_____ Email: _____

Address: _____ City/State_____ ZIP:_____ Home Phone: _____

Employer: _____How long _____ Work Phone:_____

Work Address : _____ Cell Phone: _____

Spouse-Guardian: _____ Social Security # _____Date of Birth _____

Address: _____City/State_____ZIP: _____

HomePhone: _____ Employer: _____How long? _____

Work Address : _____ Work Phone: _____

Financially responsible party: _____Relationship to patient: _____

Social Security #_____Date of Birth:_____

Address: _____ City/State_____ZIP:_____

Phone: _____ Employer/Address _____

Person to Contact in Case of Emergency

Name: _____ Address: _____City/State _____ZIP _____

Phone: Home _____Work:_____ Cell _____Relationship: _____

Is another member of your family a patient at our practice? __ YES _____ NO

How will you be paying for your dental treatment? (Circle One)

1. **Pay As You Go**
2. **Credit Card**: **VISA MASTERCARD DISCOVER AMERICAN EXPRESS**
3. **Care Credit - 6 Months Interest Free**
4. **Payment in advance over $1,500.00** - (5% bookkeeping savings.)
5. **Monthly Payment Plan**- Variable monthly installments with approved credit to qualified patients. (1½% interest per month after 60 days.) If over $200 and financing is necessary, how much would **you be able to apply Monthly? _____Weekly? _____**

Signature:_____Date: _____

Primary Insurance Company Name: _____

Secondary Insurance Company Name:_____

MEDICAL HISTORY

Patient Name _____ Date _____

Purpose of Initial Visit?_____

1. Are you in good health. ---------- ❑NO . ❑YES
2. Has there been a change in your general health within the past year? ---------- ❑NO ❑YES
3. Are you under a physician's care now? ---------- ❑NO . ❑YES
   Why _____ Medical Doctor: _____
   Address:_____ Phone: _____
4. Have you been hospitalized, had a serious illness, a major operation? ---------- ❑NO ❑YES
   If Yes Explain: _____ Date: _____
5. When walking up stairs or take a walk, do you ever have to stop because of pain in your chest? ❑NO . ❑YES
6. Are you taking any **prescription** or over the counter **medications, pills or drugs**? ---------- ❑NO ❑YES
   Name:_____
7. Are you **allergic** to, or have you had an adverse reaction, to any medications or drugs? ---------- ❑NO ❑YES
   Name: _____
8. Do your ankles swell during the day? ---------- ❑NO ❑YES
9. Have you had any serious trouble associated with previous dental treatment? ---------- ❑NO ❑YES
   If so please explain: _____
10. Have you had abnormal bleeding associated with previous dental treatment? ---------- ❑NO ❑YES
11. Are you currently taking birth control pills? ---------- ❑NO . ❑YES

FOR WOMEN ONLY: Please mark. ❑ Pregnant/Trying to get pregnant ❑ Nursing

EVERYONE: *Please circle all that apply:*

Heart Failure	SID or VD(Syphilis or Gonorrhea)	Epilepsy/Seizures	Allergies or Hives
Heart Disease or Attack		Stroke	Glaucoma
Angina Pectoris	Hepatitis A (Infectious)	Cold Sores	Artificial Joint
X-Ray or Cobalt Treatment	Hepatitis B (Serum)	Ulcers	Anemia
Sickle Cell Disease	Diabetes	Blood Transfusion	Heart Pacemaker
Congenital Heart Lesions	Thyroid Disease	Liver Disease	Kidney Trouble
Psychiatric Treatment	High Blood Pressure	Nervousness	AIDS
Scarlet Fever	Chemotherapy	Emphysema	Bruise Easily
Artificial Heart Valve	Arthritis	Cough	Yellow Jaundice
Fainting or Dizzy Spells	Cortisone Medicine	Tuberculosos (TB)	Rheumatic Fever
Heart Surgery	Heart Murmur	Asthma	Hay Fever
HIV Positive	Pain in Jaw Joints	Sinus Trouble	

Have you ever had any other serious illness not listed above? ❑ No ❑ Yes-Explain _____

Please let Dr. Johnson know if you wish to talk with him privately about any problem.

Consent: As the undersigned, I hereby authorize Dr. Robert W. Johnson to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a diagnosis of my dental needs. I also authorize Doctor Johnson to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that responsibility for payment of Dental Services provided in this office for myself and my family is mine.

I agree to assign all insurance proceeds to Dr. R. W. Johnson and understand that his staff will make every reasonable effort to have my family's insurance pay all claims submitted. I understand however that it is my ultimate responsibility to collect all insurance claims submitted.

If the insurance company does not pay my, or my family's claim within 60 days after it is mailed, I agree to pay the full balance of our accounts immediately.. I agree not to delay or withhold payments for services rendered because of pending insurance coverage.

If there is an unpaid balance for any reason after 60 days I understand a billing charge will be added the account. The billing charge will be a periodic rate of 1.5% of the unpaid balance per month (or a minimum of $2.00 for a balance under $100) which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting my families accounts. I understand that where appropriate credit reports may be obtained. **If I am applying for credit, I authorize Dr. Johnson's office to check my credit.**

_____

Signature of Patient, Parent, or Responsible Party Date

Robert W. Johnson DMD, MAGD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Robert W. Johnson DMD, MAGD

Telephone: 229-995-5858 Fax: 229-995-4650

Address: 267 Stonewall ST. SE, Dawson, GA 39842

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Robert W. Johnson DMD, MAGD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{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)

_____

_____

_____

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