JOHNSON DENTAL

Welcome to our dental family!

We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect.

The focus of our practice is health-centered, preventative dentistry. We enjoy helping people actively participate in their own health care and in controlling the causes of dental disease. Further, we emphasize aesthetic restorative treatment designed for long term beauty, comfort, function and low maintenance.

We are a practice in which team members aspire to be a part of something bigger than themselves in order to make a difference in other people's lives. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires.

The first step toward complete oral health is a thorough examination and diagnosis. We want our patients to make informed choices by fully understanding their problems. The doctors will review your dental needs with you at your initial appointment or, if necessary, at a later consultation appointment.

We look forward to working with you and being a part of your health care team!

Sincerely,

Ted Johnson, D.M.D.

JOHNSON DENTAL
4855 Ward Road, Suite 700
Wheat Ridge, CO 80033
303.422.8748

PAYMENT OPTIONS

We want the handling of your account to be an extension of the professional care we provide you and your family. In order to eliminate surprises and help meet your needs, we are dedicated to offering customized financial plans. Communication is important, and therefore, one of our team members will review with you your treatment, its costs, and payment options prior to reserving an appointment time. This will allow you the ability to select the treatment to be scheduled, as well as your preferred method of payment.
Full payment is due at the time of service.
We accept Cash, Check, Visa, MasterCard, and American Express

INSURANCE

As a courtesy to you, we will file all necessary documents with your insurance company the 1st business day after your appointment if you have provided us with sufficient information of your policy. As part of the financial arrangement process, it is not possible for our office to predict the accuracy of the coverage your insurance company will provide to you. It is your responsibility as the patient, to familiarize yourself with your specific policy. We are an independent provider and we do not guarantee any benefits you will receive from your insurance company. Ultimately, the cost of treatment is your responsibility.

COMMITMENT

Our office is dedicated to providing exceptional overall care. We appreciate your cooperation. I have read the Financial Alliance. I understand, accept and agree with the Financial Alliance.

_____

Patient Signature or Responsible Party Date

JOHNSON DENTAL

PATIENT REGISTRATION

PATIENT INFO

DATE _____

FIRST NAME_____ LAST NAME _____

PREFERRED NAME_____ SEX MALE / FEMALE (CIRCLE ONE)

ADDRESS_____

CITY/STATE/ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK _____

SSN _____ BIRTH DATE _____ MARITAL STATUS _____

EMAIL _____

☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY EMAIL
☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY TEXT MESSAGE

☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ MILITARY

PATIENT IS: RESPONSIBLE PARTY OR POLICY HOLDER (Circle one or both)

RESPONSIBLE PARTY

FIRST NAME_____ LAST NAME _____

ADDRESS_____

CITY/STATE/ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK _____

SSN _____ BIRTH DATE _____ MARITAL STATUS _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO INSURED _____

INSURED SSN _____ INSURED DATE OF BIRTH _____

EMPLOYER _____INSURANCE COMPANY _____

ADDRESS _____CITY/STATE/ZIP _____

PHONE _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO INSURED _____

INSURED SSN _____ INSURED DATE OF BIRTH _____

EMPLOYER _____INSURANCE COMPANY _____

ADDRESS _____CITY/STATE/ZIP _____

PHONE _____

PLEASE PROVIDE US WITH A COPY OF YOUR PICTURE ID AND INSURANCE CARD

JOHNSON DENTAL

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, your mouth is the entrance to the entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for filling out to the best of your knowledge.

Are you under a physician's care now? If yes, whom? _____

Have you ever been hospitalized or had a major operation? If yes, please explain _____

Have you ever had a serious head or neck injury? If yes, please explain _____

Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If yes, please list below.

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO If yes: Type of tobacco? _____ Frequency? _____ Number of years used? _____

Do you use controlled substances? ☐ YES ☐ NO

Women: Are you pregnant or trying to get pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

Other, please explain _____

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

☐ AIDS/HIV Positive	☐ Excessive Bleeding	☐ Low Blood Pressure
☐ Alzheimer's Disease	☐ Excessive Thirst	☐ Lung Disease
☐ Anaphylaxis	☐ Fainting Spells/Dizziness	☐ Osteoporosis
☐ Anemia	☐ Frequent Cough	☐ Pain in Jaw Joints
☐ Angina	☐ Frequent Diarrhea	☐ Parathyroid Disease
☐ Arthritis/Gout	☐ Frequent Headaches	☐ Psychiatric Care
☐ Artificial Heart Valve	☐ Glaucoma	☐ Radiation Treatments
☐ Artificial Joint	☐ Hay Fever	☐ Recent Weight Loss
☐ Asthma	☐ Heart Attack/Failure	☐ Rheumatic Fever
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatism
☐ Blood Transfusion	☐ Heart Pacemaker	☐ Scarlet Fever
☐ Breathing Problem	☐ Heart Trouble/Disease	☐ Shingles
☐ Bruise Easily	☐ Hemophilia	☐ Sickle Cell Disease
☐ Cancer	☐ Hepatitis A	☐ Sinus Trouble
☐ Chemotherapy	☐ Hepatitis B or C	☐ Stomach/Intestinal Disease
☐ Chest Pains	☐ Herpes	☐ Stroke
☐ Cold Sores/Fever Blisters	☐ High Blood Pressure	☐ Swelling of Limbs
☐ Congenital Heart Disorder	☐ High Cholesterol	☐ Thyroid Disease
☐ Cortisone Medicine	☐ Hives or Rash	☐ Tonsilitis
☐ Diabetes	☐ Hypoglycemia	☐ Tuberculosis
☐ Drug Addiction	☐ Irregular Heartbeat	☐ Tumors or Growths
☐ Easily Winded	☐ Kidney Problems	☐ Ulcers
☐ Emphysema	☐ Leukemia	☐ Venereal Disease
☐ Epilepsy or Seizures	☐ Liver Disease	

Comments:

_____
_____
_____
_____

Please List Current Medications and Dosage:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ **Date** _____

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 and allow the office to share information about my treatment with the following individuals (please give specific names, i.e. family members, other dentists, physicians, insurance companies, attorneys, etc.):

_____ _____
_____ _____
_____ _____

_____ _____
Print Patient Name Date

_____
Signature of Patient or Responsible Party

If you are unable to reach me, you may leave a detailed message via (check all that applies):

☐ Home/Cell Phone ☐ Text Message ☐ Email

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING, PUBLIC RELATIONS, AND EXTERNAL COMMUNICATION

I, _____, authorize Johnson Dental to use and/or disclose health information about for promotional, educational and informational purposes to local, state and national media publications, including newspapers, magazines and online media.

By initialing below, I authorize the use and/or disclosure of the following information:

___ Appearance/interview by media on camera; still photos or video footage for use in publications, audio, video, television commercial, advertising or film.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ **Date:** _____
(Signature of patient/guardian/patient representative)

Printed Name: _____ **This Authorization Ends On (Date):** _____

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Your Name: _____ Date: _____

We would like to take this opportunity to welcome you to our office and thank you for giving us the opportunity to support you in your dental health. We would like to provide you with exactly the type of treatment you want. Answering the following questions will allow us to give you the type of care you are looking for.

1. I think my present state of health is:
   - o Excellent
   - o Average
   - o Poor

2. My mouth is:
   - o Very comfortable
   - o Moderately comfortable
   - o Uncomfortable

3. The appearance of my mouth is:
   - o Very Good
   - o Satisfactory
   - o Not what I would like it be

4. Regarding my natural teeth:
   - o I want to do anything to keep them
   - o I will do only what is absolutely necessary
   - o I don't care if I keep them

5. I would like my treatment to:
   - o Be the best possible in health and appearance
   - o Be very conservative
   - o Be only what is needed to stay out of pain

6. If you could change one thing about the health or appearance of your mouth, what would it be?

   _____

How long has it been since you have seen a dentist? _____
When was your last COMPLETE dental exam? _____
When was your last CLEANING? _____
When was your last FULL MOUTH X-RAYS? _____
Are you having dental problems now? _____ Explain: _____
Do you wear removable dentures or partials? _____ Are you happy with these? _____
Are you apprehensive about dental treatment? _____
Have you ever had any gum treatments? _____
Do your gums bleed, feel tender, or are irritated? _____
Do you regularly use dental floss? _____
Are you aware of grinding or clenching your teeth? _____
Do you have headaches, earaches or neck aches regularly? _____
Have you ever worn braces or other orthodontic devices on your teeth? _____

Rank the following in order in which it would KEEP YOU from having the NECESSARY DENTAL TREATMENT
(1 being the greatest concern and 4 being not concerned)

Fear of Pain___ Cost of Treatment___ Lack of Concern___ Missing Work___

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PATIENT NAME _____ DATE

ORAL DYSFUNCTION QUESTIONNAIRE

1. During sleep do you presently have an awareness of any of the following:

Please rate the magnitude of the awareness: *1=none, 10=every night*

Dry Mouth……	1	2	3	4	5	6	7	8	9	10
Thirst……	1	2	3	4	5	6	7	8	9	10
Clench / grind your teeth at night……	1	2	3	4	5	6	7	8	9	10
Snore / loud breathing sounds ……	1	2	3	4	5	6	7	8	9	10
Congestion at night ……	1	2	3	4	5	6	7	8	9	10
Poor sleep……	1	2	3	4	5	6	7	8	9	10
Morning headache……	1	2	3	4	5	6	7	8	9	10
Morning fatigue……	1	2	3	4	5	6	7	8	9	10
Pain……	1	2	3	4	5	6	7	8	9	10
Mouth breathing……	1	2	3	4	5	6	7	8	9	10
Do you smoke?	1	2	3	4	5	6	7	8	9	10
Do you use a CPAP?	**YES**			**NO**						
Do you use oxygen at night?	**YES**			**NO**						

This is the American Academy of Sleep Medicine "Risk Survey." Please answer with what is occurring presently:

Have you ever been told you stop breathing while asleep?	**YES**	**NO**
Have you ever fallen asleep or nodded off while driving?	**YES**	**NO**
Have you ever woken up suddenly with shortness of breath, gasping, or with your heart racing?	**YES**	**NO**
Do you feel excessively sleepy during the day?	**YES**	**NO**
Do you snore, or have you ever been told that you snore?	**YES**	**NO**
Have you had weight gain and found it difficult to lose?	**YES**	**NO**
Have you taken medication for, or been diagnosed with high blood pressure?	**YES**	**NO**
Do you kick or jerk your legs while sleeping?	**YES**	**NO**
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	**YES**	**NO**
Do you wake up with headaches during the night or in the morning?	**YES**	**NO**
Do you have trouble falling asleep?	**YES**	**NO**
Do you have trouble staying asleep once you fall asleep?	**YES**	**NO**

2. Epworth Sleepiness Scale (used extensively by the medical community).

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading……	_____
Watching TV……	_____
Sitting, inactive in a public place (e.g. a theatre or meeting)……	_____
As a passenger in a car for an hour without a break……	_____
Lying down to rest in the afternoon when circumstances permit……	_____
Sitting and talking to someone……	_____
Sitting quietly after a lunch without alcohol……	_____
In a car, while stopped for a few minutes in the traffic……	_____

Total… _____

Low=0-7, Moderate 8-11, High 12-15, Severe 16+