

Welcome to the practice of Stacy D. Johnson, DDS, MS

This form was created to help our team learn more about you, your wishes and needs. Please read through and complete each section which pertains to you. Thank you.

PATIENT INFORMATION

Patient Prefers to be Called (Name/Title) _____

Patient's Legal Name

First _____

Middle _____

Last _____

SS# _____

Date of Birth _____ Sex Male / Female

Marital Status: Single/Married/Divorced/Widowed

Full Time College Student? _____

Where? _____

What is the patient's address?

Street _____

City, State, Zip _____

Patients Home Phone # _____

Patients Work # & Ext. _____

Email Address _____

Do you check your email frequently? Yes / No

Patient's Employer _____

Address _____

Phone # _____

Who is responsible for payment on the Patients Accounts? _____

If Responsible Party is different than Patient (Complete Below)

Name: _____

Address _____

Phone: _____ Work # _____

Employer: _____

SS# _____ DOB: _____

How did you hear about our office? _____

PRIMARY DENTAL INSURANCE

Insured Party's Name _____

Relationship to Patient _____

Insured Address _____

Insured Home, Work, & Other Phone #'s _____

Insured DOB _____ Sex: Male / Female

Marital Status: Single / Married / Divorce / Widowed

Insured SS _____

Insured Employer _____

Insured Plan Name, Group #, &/or Contact _____

Insurance Address _____

Insurance Phone # _____

SECONDARY DENTAL INSURANCE

Insured Party's Name _____

Relationship to Patient _____

Insured Address _____

Insured Home, Work, & Other Phone #'s _____

Insured DOB _____ Sex: Male / Female

Marital Status: Single / Married / Divorce / Widowed

Insured SS# _____

Insured Employer _____

Insured Plan Name, Group #, &/or Contact _____

Insurance Address _____

Insurance Phone _____

DENTAL HISTORY

Why are you visiting the Dentist today? _____

Are you currently experiencing discomfort? Yes No

Have you had a serious problem related to any previous dental visit? _____

Do you now or have you ever experienced any clicking, pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Excellent Good Fair Poor

Are you pleased with your smile? Yes No

If "No," why? _____

Do your gums ever bleed? Yes No

If "Yes," When? _____

How many times a day do you brush? _____

How often do you floss your teeth? _____

Your toothbrush bristles are Soft Medium Hard

When was your last dental visit? _____

Previous Dentist & Services Provided: _____

MEDICAL CHECKLIST

Do you have or ever experienced any of the following?

Please circle all areas that apply.

| | | |
|--------------------------------------|-----------------------------------|--|
| Allergies (Environmental) History | Allergies (Drug) | Please See Health History |
| Arthritis | AIDS/HIV + | Artificial Bones/ Joints |
| Cancer: Location: _____ | Chemotherapy/ Radiation Treatment | Congenital Heart Defect |
| Diabetes Problems | Difficulty Breathing | Asthma/Lung |
| Drug/Alcohol Concerns | Eye Problems/ Glaucoma/ Contacts | Epilepsy/Seizures |
| Fainting/Dizziness | Fever Blisters/ Herpes | Fibromyalgia |
| Heart Murmur/ Heart Attack/Disease | Heart Surgery/ Pacemaker | Hemophilia/Anemia Abnormal Bleeding |
| Hepatitis/ Type: ____ Liver Problems | High/Low Blood Pressure | Kidney/Bladder Problems |
| Latex Allergy | Medication Allergy: _____ | Mitral Valve Prolapse/ Artificial Heart Valves |
| Psychiatric Care/ Emotional Concerns | Rheumatic Fever/ Scarlet Fever | Severe/ Frequent Headaches |
| Sinus Problems | Stroke | Sexually Trans. Disease |
| Thyroid Disease | Tuberculosis | Ulcers/Colitis |

Do you now or have you ever experienced any of the following? (Please circle all that apply.)

| | |
|--|--------------------------------|
| Injury to head/jaw/neck | Blisters in mouth/lips |
| Food impaction in teeth | Unfavorable dental experience |
| Unpleasant taste/breath | Clenching or grinding |
| Mouth breathing | Complications from extractions |
| Periodontal treatment | Swelling or lumps in mouth |
| Difficulty opening/closing | Orthodontic treatment |
| Sensitivity to cold/heat/sweets/pressure | |
| Sounds/pain around ear when eating | |
| Red/White patches/growths on tongue | |
| Cigarette/cigar/pipe/smokeless tobacco | |
| Oral Habits/Nail biting/Cheek biting | |
| Other: | |

MEDICAL HISTORY

Do you have a Medical doctor? Yes No
Physician's Name & Phone # _____
Date of Last Visit _____
Last Hospitalization _____
Your current physical health is: Excellent Good Fair Poor
Please explain. _____
Are you taking prescriptions or over-the-counter medications?
Please list each one, including vitamins, minerals and/or herbs. (Use back of page if necessary.) _____

Please list all allergies (medications & environmental).

Have you had any adverse reaction to local anesthesia? (Used for numbing.) Yes No
Have you been advised to take antibiotics before dental procedure? Yes No
Have you taken Redux or Phen-Fen for diet control? Yes No
For Women: Are you pregnant? Yes No No. of Weeks: _____
Are you nursing? Yes No
Taking birth control pills? Yes No

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance of operations & conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I authorize Stacy D. Johnson, DDS, MS, to release any information to a third party &/or health practitioners. I authorize & request my insurance company to pay Dr. Johnson directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services & I unconditionally agree to be responsible for and to pay all charges incurred, whether such services are for my benefit or for the benefit of the above named patient, regardless of any possible reimbursement from third parties. I agree & understand in the event I do not pay Dr. Johnson, the balances due, and my account is placed in the hands of a collection agency &/or Attorney for collection proceedings, I will be legally responsible for all Attorney/collection fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by Dr. Johnson, &/or assignees. I further understand a 1 ½ % finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. I agree to pay Dr. Johnson, a minimum fee of \$50 for any appointment I schedule & fail to arrive for or cancel with less than 48 hours advance notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Dr. Johnson, of any changes in my personal or medical status. I authorize Dr. Johnson, or a qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian.

Dr. Stacy Johnson, DDS, MS

Patient Consent For Use AND Disclosure Of Protected Health Information

I hereby give my consent for Dr. Stacy Johnson, DDS MS to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.(TPO) The Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Stacy Johnson, DDS MS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Stacy Johnson, DDS, MS. Attn: Front Desk, 3056 W. Stones Crossing Rd. Greenwood, IN 46143.

With this consent Dr. Stacy Johnson, DDS MS may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Stacy Johnson, DDS MS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Dr. Stacy Johnson, DDS MS may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request restriction of how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Stacy Johnson, DDS MS use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Stacy Johnson DDS MS may decline to provide treatment to me.

Receipt of Notice of Privacy Practice – Written Acknowledgement

I have received a copy of Dr. Stacy Johnson, DDS MS’s Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Printed Name of Patient

Date

Information Can Be Released To:

Name

Relationship

Name

Relationship

WE DO NEED COPY OF THE POWER OF ATTORNEY FOR PATIENT CHART

Stacy D. Johnson, DDS, MS
Financial Menu

Thank you for choosing our practice for your family dental care. Our goal for our patients is to experience a pleasant dental environment, while providing the finest care available. We strive to keep our patients families well informed of their dental needs, treatment alternatives, as well as financial options to make your total dental experience as comfortable as possible. This menu is designed to help you better understand our financial policies.

PAYMENT

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, debit cards, checks and cash are accepted. As dental needs are diagnosed, a treatment plan will be provided showing these needs, estimated fees and payment due to begin treatment. If a financial concern is anticipated, in which payment in full as arranged cannot be remitted, please inform our office immediately. We offer approved extended payment plans through an outside source.

DENTAL INSURANCE

If you have the benefit of dental insurance, we accept most Primary Insurance Plans that do not require a specific provider. Please bring your identification card, signed insurance form and benefit booklet to your first visit. Dental insurance is not intended to be a “pay-all” service, but to help reduce “out-of-pocket” expenses. We will file Primary Dental Insurance Claims. Please be prepared to pay deductible and estimate co-payment in full as treatment is initiated. Please note, we do not accept assignment of benefits for Secondary Insurance. Therefore, after Primary Insurance responds any remaining balance is due in full. As a courtesy, we will prepare a Secondary Insurance Claim form, submit the claim and request the carrier reimburse the subscriber directly.

INSURANCE PAYMENT

As a courtesy, we will file your Primary Insurance Claims and are willing to wait up to 60 days from date of service for the insurance to respond. We will contact your carrier and determine if there is a delay and strive to resolve the delay, a statement will be forwarded and payment is due in full by responsible party. We'll instruct the dental carrier to reimburse the Insured Party directly. As a healthcare provider, our relationship is with you, not your insurance company. Our primary concern is for the well-being of your family and structure our care accordingly. Insurance companies determine benefit packages and payment rates (usual and customary fees –UCR) by the type of plan that is purchased by the employer/insured party-not the level of care the patient needs. All charges are your responsibility from the date services are rendered, regardless of insurance benefits, arbitrary determination of UCR, or lack thereof.

APPOINTMENTS

We see patients on a “by appointment” basis and ask you to call in advance to reserve time for your family. If you experience a scheduling conflict with a reserved appointment, please provide at least 24 hour advance notice for scheduling changes. In instances where appointments are cancelled or failed with 24 hours notice or less, a fee of \$50 per hour may be charged to your account.

RETURNED CHECK FEE

A fee of \$20.00 or 5% of the balance, whichever is greater will be charged for any returned check. After two returned checks are received, the account will be placed on a “cash only” basis. The outstanding balance and returned check fee must be paid immediately upon notification from our practice and prior to the next scheduled appointment.

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I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance or operations and conduct of laboratory, x-ray, or other studies that may be sued by the attending Doctor, staff or qualified designate. I authorize Stacy D. Johnson, DDS, MS to release any information to a third party and/or health practitioners. I authorize and request my insurance company to pay Stacy D. Johnson, DDS, MS directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services and unconditionally agree to be responsible for and to pay all charges incurred on my behalf or my dependants. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or if no such arrangements are made, then payment shall be made in full within fifteen (15) days of discharge. I/We that in the event of default in payment, reasonable collection agency fees, reasonable attorney fees and incidental expenses shall be added to the amount due on the account, plus any applicable court costs. I further understand a 1/5% finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. I agree to pay Stacy D. Johnson, DDS, MS a minimum fee of \$65 for the first hour and \$25 for every half hour proceeding for any appointment I schedule and fail to arrive or cancel with less than 24 hours advance notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Stacy D. Johnson, DDS, MS of any changes in my personal or medical status. I authorize Stacy D. Johnson, DDS, MS or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian and consent to treatment on their behalf.

Patient Name _____ Date: _____

Signed _____ Date: _____

My Signature confirms I am legally the Responsible Party, Parent or Authorized Guardian for the patient listed above.