Oral & Implant
Surgery Specialists, P.C.
DR. D. M. (KEN) JOHNSON

PATIENT # ________

PATIENT INFORMATION

Patient Name ______________________ Age________ Date of Birth______________

Street Address ____

City ______________ State ________ Zip _______ Email ______________@______________

Sex ◎ M ◎ F ◎Single ◎Married ◎Divorced ◎Widowed

Phone Numbers (Please ✓Preferred) ◎ Home ____-____-____ ◎ Cell ____-____-____ ◎ Office ____-____-____ ◎ Other ____-____-____

◎ YES ◎ NO I consent to receive texts to remind me of appointments or schedule changes

Emergency Contact ______________ Phone ____-____-____ Relationship ______________

IF PATIENT IS A MINOR: Name of Parent/Guardian ______________________ Phone ____-____-____

Dentist ______________________ Phone ____-____-____

Orthodontist ______________________ Phone ____-____-____

Primary Care MD ______________________ Phone ____-____-____

Other MD treating you ______________________ Phone ____-____-____

Preferred Pharmacy ______________________ Phone ____-____-____

Referred by ◎ Dentist ◎ Orthodontist ◎ Physician ◎ Other______________

Did you bring a referral form? ◎ Yes ◎ No Did you bring a current X-ray? ◎ Yes ◎ No

MEDICAL INSURANCE

Policy Holder Name______________________ Date of Birth____________ Phone #____-____-____

Employer ______________________ Insurance Name______________________

SS# ____-____-____ Subscriber ID #______________ Group #______________

Patient's Relation to Person Responsible for Payment ◎ Self ◎ Spouse ◎ Child ◎ Other ______________

DENTAL INSURANCE

Policy Holder Name______________________ Date of Birth____________ Phone #____-____-____

Employer ______________________ Insurance Name______________________

SS# ____-____-____ Subscriber ID #______________ Group #______________

Patient's Relation to Person Responsible for Payment ◎ Self ◎ Spouse ◎ Child ◎ Other ______________

NOTICE OF PRIVACY POLICY - PATIENT ACKNOWLEDGEMENT

I, ________________, hereby authorize Oral and Implant Surgery Specialists, PC to furnish information to insurance carrier(s) concerning my diagnosis and treatment. I authorize Oral and Implant Surgery Specialists, PC, and affiliated business associates to contact me regarding appointments and billing inquiries.I I acknowledge that I was offered a copy of the Notice of Privacy Practices Policy by Oral & Implant Surgery Specialists, PC on the date indicated below. I also specifically authorize Oral & Implant Surgery Specialists PC to discuss my personal health information with the following:

NAME	RELATIONSHIP	PHONE NUMBER(S)
______________	______________	____-____-____
______________	______________	____-____-____
______________	______________	____-____-____

Signature ______________________________ Date ______________

Printed Name ______________________ Relation to Patient ______________

CONFIDENTIAL HEALTH HISTORY

Reason for your visit with us:

DENTAL HISTORY

◎N ◎Y Are you having dental pain or toothache?

◎N ◎Y Are you having gum or facial swelling?

◎N ◎Y Are you taking medications for this?

If yes: Antibiotics: ◎ Amoxicillin / Penicillin ◎ Cleocin / Clindamycin ◎ Other ___________________________

Prescription Pain Meds: ◎ Hydrocodone ◎ Oxycodone ◎ Other___________________________

◎ Aspirin ◎ Tylenol / Acetaminophen ◎ Advil / Ibuprofen ◎ Aleve / Naproxen ◎ Other______________________

◎N ◎Y Do you wear full or partial removable dentures? ◎N ◎Y Having problems with them?

◎N ◎Y Interested in dental implants to replace missing teeth / teeth to be extracted / support dentures?

ALLERGIES

Check or list any allergies: ◎ No drug or contact allergies except for seasonal allergies

◎ Latex ◎ Penicillin / Amoxicillin / Augmentin ◎ Cleocin / Clindamycin ◎ Erythromycin / Z-pak ◎ Sulfa

◎ Hydrocodone ◎ Oxycodone ◎ Codeine ◎ Aspirin ◎ NSAIDs ◎ Advil / Ibuprofen / Motrin ◎ Aleve / Naproxen

◎ Local Anesthetics: ◎ Lidocaine / Xylocaine ◎ Septocaine / Articaine ◎ Novacaine ◎ Marcaine ◎ Epinephrine

◎ Topical Anesthetics (rubbed on gums before injections): ◎ Valium ◎ Cortisone Drugs ◎ Eggs ◎ Peanuts

◎ Any other allergies? List…

TREATMENT

Check all that apply:

◎ Under Pain Management Doctor Care?

◎ Treatment for Drug/Alcohol dependance?

◎ Taking medications for panic or anxiety attacks

◎ Osteopenia / Osteoporosis Meds

If yes: ◎Injections ◎Oral ◎IV How long? ____ yrs

◎ Smoker ◎ Smokeless Tobacco ◎ E-Cig

◎ Artificial Joints

◎ Sleep Apnea - ◎ Use CPAP Machine?

◎ Radiation for cancer of head or neck?

◎ Cancer Chemotherapy - ◎ IV ◎ Oral

◎ HIV ◎ Compromised Immune system

MEDICAL ISSUES

General Health: ◎ Good ◎ Fair ◎ Poor ◎ NO SERIOUS HEALTH ISSUES Check all that apply below:

Condition	New	Prior	No	Condition	Now	Prior	No	Condition	Now	Prior	No
Heart Surgery				Kidney Trouble				Asthma			
Lung				Cancer Tumor				Emphysema			
A-FIB				Dementia				Bipolar			
Hepatitis				Stroke				Austism			
High Blood Pressure				Liver Trouble				ADD / ADHD			
Diabetes				Neurological				TMJ / Jaw Joint Problems			
Arthritis				Skeletal / Bone				If Yes: ◎Popping ◎Locking ◎Pain ◎Mouth Guard ◎Surgery			

I understand that providing incorrect or incomplete information or omissions could result in negative treatment outcomes or complications. I have reviewed this health history and affirm that all questions have been answered correctly to my knowledge. I understand that I may ask questions if I do not understand, and that I should not agree to any oral surgery treatment unless I feel that my medical conditions have been properly addressed. Oral contraceptives may be rendered ineffective when taken concurrently with antibiotics, especially penicillin's or tetracycline's, and other medications have been implicated. Breakthrough bleeding may indicate this has occurred. THIS COULD RESULT IN UNPLANNED PREGNANCY! It is strongly recommended that additional methods of contraception be used while on these medications through the completion of your contraceptive cycle. If questions, contact your physician for additional information. I have read and understand the above.

Signature____ Printed Name_____________________________________ Date_______________________

MEDICATIONS

Please list any and all medications you are currently taking or have taken in the last year.

Include prescription medications, diet drugs, over-the-counter medications, herbal/holistic remedies, vitamins or minerals.

MEDICATION NAME	TIME TAKEN	DOSE	INSTRUCTIONS

Signature____ Date________________________

OFFICE USE ONLY - DETAILS OF MEDICAL HISTORY

FINANCIAL POLICIES

WELCOME TO OUR ORAL & MAXILLOFACIAL SURGERY OFFICE

◎ We will accept assignment of claims, however, all deductibles and fee amounts not covered by Insurance are estimated and due at the time of treatment.

◎ Our office will file your claims to the insurance company. We will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation if necessary.

◎ We do not file insurance for one extraction, unless we are in network with the insurance company. We will provide you with a statement that you can attach to your claim form for reimbursement.

◎ In order to honor any insurance benefits, you must provide insurance identification cards.

◎ Outside laboratory services: Some procedures require specimens to be sent to an outside laboratory. Fees for the laboratory services will be billed by the company NOT this office.

◎ If your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $30.00.

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINED ABOVE

Signed: ____ Date: ____________________

TO BE FILLED OUT AT TIME OF CHECK OUT

The information provided below is an estimate of the charges for the services provided. Your insurance company has been contacted to verify appropriate coverage. Since insurance companies and carriers will not give guarantees for payment over the phone, the ultimate responsibility for any services remains with you. We will file your insurance claim for services and all charges not covered by your insurance and any coinsurance, deductibles and co-payments will be your responsibility.

◎ I understand that the amounts presented below are only ESTIMATES.

CONSULTATION: Visit total fee: $____________ Estimated Patient Potion: $____________

TREATMENT: Visit total fee: $____________ Estimated Patient Potion: $____________

Deductible: *$____________* *Met* *or* *Not Met*

Max Benefits: *$____________* *Used to Date:* *$____________* *Remaining for year:* *$____________*

◎ I agree to the above estimated amount due from patient to settle the outstanding balance.

◎ I authorize D.M. Johnson Jr., DMD, PC representatives to file claims for reimbursement of these charges and to release appropriate medical information for this purpose. I further authorize payment for these services to be paid to D.M. Johnson Jr., DMD, PC.

Patient / Guarantor Signature:________________________________Relationship:__________________Date:____________