J. BRUCE JOHNSON, D.D.S.
www.bodymindandsmiles.com

Creating Radiant Smiles

3909 Ocean View Blvd., Montrose, CA 91020
Ph: (818) 248-7976 Fax: (818) 248-9662

Today's Date: ___/___/___ **Reason for Visit:**_____ **Are you currently in pain?** Y N

Name: _____ ❑ Male ❑ Female I Prefer to be Called: _____
TITLE FIRST MI LAST ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Birthdate: ___/___/___ Age: ____ SS# _____ DL#: _____ E-Mail: _____

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Occupation: _____

Person Responsible for Account: _____ Relationship: _____ Birthdate: ___/___/___ SS#: _____

Present / Previous Dentist: _____ Who may we thank for referring you? _____
(PLEASE CIRCLE ONE)

In case of Emergency, contact: _____
NAME RELATIONSHIP PHONE

DENTAL HISTORY

When is the last time you saw a dentist? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Y N Have you ever taken Fen-Phen (Redux or Pondimin)?
Y N Have you ever taken Fosomax or other bisphosphonates?
Y N Do you require antibiotics before dental treatment?
Y N Do you have mobility in any of your teeth?
Y N Have you lost or had any permanent teeth extracted?
Y N Do you have sensitivity to heat, cold, pressure or anything else?
Y N Do you now or have you ever experienced pain or discomfort in your jaw joints?
Y N Have you ever had any jaw joint treatment?
Y N Have you ever had any orthodontic treatment?
Y N Would you like fresher breath? Whiter Teeth? Y N

When was your last dental cleaning? _____

How many times daily do you brush? ____ Weekly floss? ____

Y N Do you use anything in addition to a toothbrush & floss?
Y N Do you have a **Latex** allergy?
Y N Do your gums ever bleed?
Y N Have you ever had gum treatment?
Y N Do you have partials or dentures? When placed: _____
Y N Have you ever had a serious problem associated with any previous dental treatment or anesthetic?
Y N Have you ever experienced abnormal bleeding with surgery or extractions?
Y N Do you have any sores or lumps in or near your mouth?

How would you rate your smile? Worst 1 2 3 4 5 Best

MEDICAL HISTORY

Physician: _____ City: _____ Your current physical health is: ❑ Good ❑ Fair ❑ Poor

List <u>any</u> substance(s) you are **<u>allergic</u>** to: _____

List any **<u>medications</u>** you are taking: _____

Y N Have you been hospitalized for any surgical operation or serious illness? Explain: _____

Y N Are you currently undergoing medical treatment? Explain: _____

Have you ever had, currently or in the past, any of the following conditions? Please circle yes (Y) or no (N) for each item below.

Y N AIDS / HIV / ARC
Y N Adenoids / Tonsils Removed
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma / Respiratory Disease
Y N Blood Disease
Y N Blood Transfusion
Y N Cancer / Tumors / Leukemia
Y N Chest Pains / Angina
Y N Chicken Pox / Shingles
Y N Chronic Fatigue / Fibromyalgia
Y N Circulatory Problems
Y N Congenital Heart Defect
Y N Cortisone Treatments
Y N Cough -Persistent or Bloody
Y N Diabetes / Hypoglycemia
Y N Downs Syndrome
Y N Easily Winded
Y N Emphysema
Y N Epilepsy / Seizures / Fainting
Y N Frequently Tired
Y N Glaucoma
Y N Gout
Y N Hay / Scarlet / Rheumatic Fever
Y N Heart Attack / Stroke
Y N Heart Disease
Y N Heart Murmur
Y N Heart Palpitations
Y N Hemophilia
Y N Hepatitis Type: A B C
Y N Herpes / Fever Blisters
Y N High / Low Blood Pressure
Y N Immune System Disorder
Y N Kidney Problems / Disease
Y N Liver Problems / Disease
Y N Metal Rods / Pins / Implants
Y N Mitral Valve Prolapse
Y N Multiple Sclerosis
Y N Muscular Dystrophy
Y N Nervous Problems
Y N Neuralgia
Y N Osteoporosis
Y N Parkinson's Disease
Y N Pacemaker
Y N Psychiatric Care / Disorders
Y N Rheumatism
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Skin Disorder
Y N Slow Healing Sores
Y N Special / Restricted Diet
Y N Steroid Therapy
Y N Swollen Ankles
Y N Unexplained Weight Loss / Gain
Y N Thyroid Problems
Y N Tobacco Use
Y N Tonsilitis
Y N Tuberculosis (TB)
Y N Ulcers / Colitis
Y N Urinary Disorders
Y N Venereal Disease
Y N Radiation / Chemotherapy

WOMEN ONLY

Y N Are you currently nursing?
Y N Are you, or is there a possibility you may be **pregnant**?
Due Date: _____
Y N Do you take any hormones (HRT, birth control)?
Y N Do you experience strong symptoms associated with menstruation (nausea, cramping, headaches)?

JAW RELATED
- ❑ Jaw Clicking / Popping [524.63]
- ❑ "Gritting" in Joints on open / close [524.64]
- ❑ Jaw has locked: open closed [718.28]
- ❑ Jaw locks repeatedly: open closed [718.38]
- ❑ Spontaneous shooting pain near joints [350.1]
- ❑ Teeth Clenching / Grinding [306.8]
- ❑ Limited opening of mouth [524.52]
- ❑ Jaw Deviates to side on open / close [524.53]
- ❑ Jaw Joint Pain [524.62]
- ❑ Generalized Jaw Pain [526.9]

MOUTH & NOSE RELATED
- ❑ Dry Mouth [527.7]
- ❑ Mouth Breather [524.59]
- ❑ Frequent Snoring
- ❑ Difficulty Breathing / Shortness of Breath
- ❑ Irritated Gums or Pain / Sensitivity in teeth
- ❑ Frequently bite cheeks, lips, or tongue
- ❑ Deviated Septum

BACK / NECK RELATED
- ❑ Shoulder Pain / Stiffness
- ❑ Neck Pain [723.1]
- ❑ Limited Neck Movement
- ❑ Back Pain: Lwr Mdl Upr

HEAD & FACE RELATED
- ❑ Tension Headaches [307.81]
- ❑ Frequent Headaches [784.0]
- ❑ Facial Pain [350.2]
- ❑ Painful/Inflamed Facial Muscles [729.1]
- ❑ Head/Neck/Face Muscle Spasms [728.85]

EAR RELATED
- ❑ Ringing in the Ears [388.31]
- ❑ Ear Congestion
- ❑ Ear Pain [388.70]
- ❑ Hearing loss / Impairment
- ❑ Recurrent ear infections

EYE RELATED
- ❑ Blurred Vision
- ❑ Pain in / around the eyes [379.91]
- ❑ Photophobia / Aura

THROAT RELATED
- ❑ Chronic sore throat / swollen glands
- ❑ Frequent Cough / Colds
- ❑ Chronic Congestion

OTHER
- ❑ Vertigo (Dizziness) [780.4]
- ❑ Fatigue
- ❑ Muscle Twitching or Tremors
- ❑ Numbness / Tingling in hands or fingers
- ❑ Swelling in the feet or ankles
- ❑ Learning Disabilities

SLEEP RELATED
- ❑ Insomnia
- ❑ Sleep Disturbances

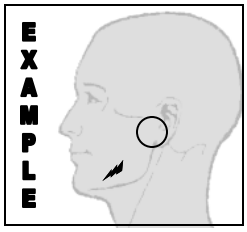
Y N Do you frequently wake up during your sleep time?
Y N Do you have sore or tired facial, head, or neck muscles or headaches upon waking in the morning?
Y N Have you ever been diagnosed with a sleep disorder?
Y N Has a physician ever diagnosed you with Obstructive Sleep Apnea? [327.23]

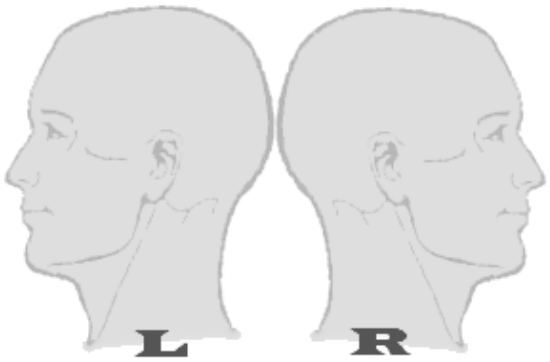
If yes, name of physician and when diagnosed:

_____

INJURIES & PAIN

Use the diagram to indicate injury to an area by circling it and pain in an area by coloring it in.





Y N Have you had any injuries to the head, face, neck, or jaw? If yes, please explain and indicate on diagram:

_____

_____

_____

Y N Have you ever been in a car accident? Describe:

_____

_____

_____

Please check any of the following care providers you have sought care from, currently or in the past:

❑ Chiropractor ❑ Osteopath ❑ Cranial Therapist ❑ Podiatrist ❑ Neurologist ❑ Speech Therapist ❑ Nutritionist

Please list any herbal remedies, vitamins, minerals, or other supplements you are taking not listed elsewhere on this form:_____

_____

Please list any medical issues or concerns not otherwise indicated on this form: _____

_____

I affirm that the information I have provided is complete and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and understand it is my responsibility to inform this office of any changes in my medical status. I have reviewed to my satisfaction or declined to review the *Dental Materials Fact Sheet, Dental Oxygen/Ozone Therapy Information,* and the *Notice of Privacy Practices* and understand them. I hereby give my consent to any advisable and necessary diagnostic or dental procedures, medications, or anesthetics and understand that I am responsible for payment of services rendered. I authorize the release of information to J. Bruce Johnson, D.D.S., from any past or current health care provider, and the release of my medical / dental records to other health care providers whose care I am or may come under. I understand that any diagnostic and treatment records remain the property of the doctor but are available for referral. I consent to the use of these records by Dr. Johnson without my identity being revealed.

_____

Signature of Patient, Parent, or Legal Guardian Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

THIS SECTION FOR OFFICE USE ONLY

Date:_____ Reviewed by (staff initials):_____ Doctor's Signature _____

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FINANCIAL AGREEMENT

Our practice is committed to providing optimal treatment for our patients based on a diagnosis of what is in the best interest of their dental and overall health & well-being. We do not negotiate fees or adjust treatment due to insurance restrictions.

1. PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.
2. WE ACCEPT *CASH*, *CHECK*, *VISA / MASTERCARD*, *DISCOVER*, *AMERICAN EXPRESS, & CARE CREDIT* .
3. APPOINTMENTS CANCELLED LESS THAN 48 BUSINESS HOURS ARE SUBJECT TO A BROKEN APPOINTMENT FEE.
4. WE WILL PREPARE & SUBMIT CLAIMS FOR APPLICABLE PPO / DPO DENTAL INSURANCE.
5. NO SERVICES CAN BE SUBMITTED TO HMO / DMO INSURANCE PLANS, MEDICARE, DENTI-CAL, OR OTHER SIMILAR PROGRAMS. MEDICAL INSURANCE MAY COVER CERTAIN PROCEDURES; WE WILL PROVIDE ASSISTANCE FOR YOU TO SUBMIT CLAIMS IF YOU HAVE A PPO MEDICAL INSURANCE PLAN.

_____ INITIAL HERE

Please be prepared to make payment at the time of your appointment. Any alternate arrangements must be made with the front desk prior to your appointment. An account is deemed delinquent if payment is not received in accordance with this policy or a separate mutually agreed upon arrangement. Delinquent accounts are subject to a finance charge of 18% APR (regardless of insurance) and no further treatment can be scheduled until the balance is resolved. You agree to pay all legal expenses necessary for the collection of any debt.

_____ INITIAL HERE

Checks are accepted with proper identification. There is a returned check fee of $35 and alternate means of payment may be required for future charges. A Broken Appointment Fee of $50 is applicable to any appointments not cancelled or rescheduled with a staff member at least 48 business hours prior to the appointment time.

_____ INITIAL HERE

If you have a PPO / DPO Dental Insurance Plan, we will prepare and submit claims provided you complete the Insurance Agreement with valid information with the understanding that you are responsible for payment of services rendered. Your estimated patient portion is due at each visit. Once your insurance has made payment to our office (Assignment to Doctor), or **31 days** from the date of submission, any remaining balance will be charged to your credit card on file.

_____ INITIAL HERE

If you do not maintain a credit card on file, any remaining balance must be paid within 30 days of the insurance payment, or 31 days from the date of submission, or you may forfeit your Assignment to Doctor status; you will be required to make payment in full when services are rendered and be reimbursed by your insurance company.

_____ INITIAL HERE

If you have medical insurance, please read the back of this form, initial where appropriate, sign and date. HMOs, Medicare, and similar programs will not reimburse and cannot be billed for services rendered in this office. If you are covered by Medicare please check the box on the back of this form, read thoroughly, sign and date.

_____ INITIAL HERE

Flexible Spending/Savings Accounts vary greatly. It is your responsibility to know the requirements of your plan, request documentation in a timely manner and meet your deadlines. We can only run cards in your presence and reversals of charges cannot be handled by our office.

_____ INITIAL HERE

By having services rendered you agree that you are ultimately responsible for all charges incurred. This agreement applies to any patient for which you are the account guarantor and supersedes all prior agreements signed. In the event that financial responsibility changes, you understand that you remain financially responsible until a new agreement is signed and accepted by our office.

_____ _____ _____ _____

Patient Name (If other than Guarantor) Guarantor Name Social Security # Driver's License #

Signature of Account Guarantor _____ Date_____

CREDIT CARD ON FILE: "I authorize Dr. J. Bruce Johnson to charge this credit card in accordance with the above agreement. "

_____

PRINT CARDHOLDER NAME CARDHOLDER SIGNATURE

_____ _____-_____-_____-_____ ___/___ _____ _____

TYPE OF CARD CARD # EXP. DATE CVV CODE BILLING ZIP CODE

INSURANCE AGREEMENT

REV 0713

Please present your insurance card(s). All fields are required in order for us to assist you with your insurance.

Primary Dental Insurance Company

INS. CO. NAME: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ SS #: _____

SUBSCRIBER ID #: _____ PATIENT'S SS #: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

INSURED'S EMPLOYER: _____

(IF INSURANCE IS THROUGH EMPLOYER)

EFFECTIVE FROM: ___/___/___ EFFECTIVE UNTIL: ___/___/___

Secondary Dental Insurance Company

INS. CO. NAME: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ SS #: _____

SUBSCRIBER ID #: _____ PATIENT'S SS #: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

INSURED'S EMPLOYER: _____

(IF INSURANCE IS THROUGH EMPLOYER)

EFFECTIVE FROM: ___/___/___ EFFECTIVE UNTIL: ___/___/___

❑**"I am covered by Medicare"** I understand that services provided by Dr. Johnson will not be covered by Medicare (or other similar programs) and that by seeking treatment from Dr. Johnson I am privately contracting for his services. I agree not to make submissions to Medicare for services rendered by Dr. Johnson and understand that his office will not make submissions to Medicare (or other similar programs) for services rendered. **I am opting-out of Medicare benefits for services which may have otherwise been covered by Medicare.**

MEDICARE OPT-OUT: _____

SIGNATURE DATE

_____ INITIAL HERE You are entering into a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for treatment. **The doctor is not a party to your contract with your insurance company. By assisting with or submitting insurance claims and / or accepting assignment of your insurance benefits we are in no way releasing you of your financial obligations and responsibilities.**

_____ INITIAL HERE As a courtesy, we will prepare and submit claims on your behalf to applicable PPO / DPO primary and secondary dental insurances. You are responsible for 1) providing complete, accurate insurance information and notifying our office of any changes in coverage 2) tracking or ensuring payment of claims and resolution of delays or disputes by your insurance company. In the event your insurance company states they have not received a claim, we will gladly make **one** duplicate submission. If the problem persists, we will provide you a copy of your claim to resubmit.

_____ INITIAL HERE The estimated patient portion, including any deductible, on covered services and 100% of non-covered services is due at the time of each visit. You are responsible for resolving disputes which may delay the processing and payment of claims. If a claims is pending after **31** days from submission, you may be required to make payment. Any balance remaining after a claim has been paid by your insurance company will be charged to your credit card on file; if you do not maintain a credit card on file, payment must be made no later than 30 days from the date the claim is processed or you may forfeit your *Assignment to Doctor* status.

_____ INITIAL HERE If you fail to fulfill the terms of the financial agreement (making timely payment of any remaining balance after claims processing), payment is **due in full when services are rendered** and your insurance company will be instructed to send any reimbursement directly to you.

_____ INITIAL HERE If your condition & treatment are medical in nature, you may submit claims to your medical insurance carrier so long as it is a PPO type plan. If you wish to submit medical claims notify the front desk when you check out from your appointment(s). If your medical insurance company requires a narrative or other non-standard documentation, we may or may not be able to provide proper assistance and fees may apply for preparation of paperwork.

AUTHORIZATION FOR SUBMISSION OF CLAIMS / ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize J. Bruce Johnson, D.D.S. to submit claims for services performed to the healthcare service plans or insurance companies under which I (or my dependents) am covered. These claims are to be submitted on my behalf and the benefits which would otherwise be payable to me may be assigned to J. Bruce Johnson, D.D.S.. I understand that my dental insurance carrier may pay less than the actual bill for services; I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby give permission to Dr. J. Bruce Johnson to release all information necessary to secure the payment of benefits by any person or corporation (1) which is or may be liable or under contract to Dr. Johnson for reimbursement for services rendered, and (2) any health care provider for continued patient care. This includes the legal guardian of patients over the age of 18 who are covered under the guardian's health/automobile insurance. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____ _____

PATIENT OR GUARANTOR: NAME SIGNATURE DATE