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.

ABOUT 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

Address: _____

City, State, Zip: _____

Patients Home Phone #_____

Patients Work # & Ext._____

Cell Phone # _____

Email Address:_____

Do you check your email frequently? Yes/No

Patients 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?_____

_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insured Parties 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 Parties 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: No/Yes

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

_____

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? _____

Are your toothbrush bristles: Soft/Medium/Hard

When was your last dental visit? _____

Previous Dentist & Services Provided: _____

_____

Do you have or ever experienced any of the following?

Please underline all that apply:

Sensitivity to cold/heat/sweets/pressure	Food Impaction in teeth
Unfavorable dental experience	Unpleasant Taste/Breath
Clenching or Grinding	Mouth Breathing
Complications from Extraction's	Periodontal Treatment
Red/White patches/growths on tongue	Orthodontic Treatment
Swelling or lumps in mouth	Difficulty opening/closing
Sounds/pain around ear when eating	Injury to head/neck
Cigarette/Cigar/pipe/smokeless tobacco	Blisters in mouth/lips
Oral Habits/Nail Biting/Cheek Biting	Other:_____

NOTES:_____

_____

Acknowledgement and Authority

MEDICAL CHECKLIST

Do you have or ever experienced any of the following?

Please underline all areas that apply.

Allergies (Environmental)	Allergies (Drug)	Please See Health History
Arthritis	AIDS/HIV +	Artificial Bones/ Joints
Cancer:	Chemotherapy/	Congenital Heart Defect
Location:_____	Radiation Treatment	
Diabetes	Difficulty Breathing	Asthma/Lung Problems
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: ___	High/Low	Kidney/Bladder
Liver Problems	Blood Pressure	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

Medical History

Do you have a Medical Doctor? Yes NO

Physicians 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 &/or herbs).

_____

_____

Please list all allergies you have (medications & Environmental):

_____

Have you had any adverse experience to Local Anesthesia? (Used for numbing) Yes No

Have you been advised to take antibiotics pre-medication before dental procedures? Yes No

Have you taken Redux or Phen-Fen for diet control? Yes No

For Women: Are you pregnant? Yes No Week

Are you nursing? Yes No Taking Birth Control Pills? Yes No

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 per hour for any appointment I schedule & fail to arrive for 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 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.

Name:_____Date:_____

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 of 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, American Express, 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 was 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 at that time 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 of 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 form our practice and prior to the next scheduled appointment.

ACKNOWLEDGEMENT AND AUTHORITY

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 dependents. 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 understand 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 15% 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 $50 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.