Jo-Anne Johnson D.M.D.
FAMILY DENTISTRY
174 Route 101 Unit C1
Bedford, NH 03110
(603) 471-6000

Patient Name: _____ _____ __ _____
Last First MI Preferred Name

Gender: ☐ Male ☐ Female ☐ Other / Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birthdate: _____ SS#: _____ Email Address: _____

Phone: _____ _____ _____ _____
Home Work Ext Cell

Address: _____ _____ _____ _____
City State Zip Code

Insurance Information:

Subscriber Name: _____ Employer_____

SS# of Subscriber: _____ Birthdate of Subscriber _____

Address of Subscriber (if different): _____ _____ ___ _____

Insurance Company: _____ Group Name: _____

Subscriber ID #: _____ Group #: _____

Emergency Contacts:

Primary Emergency Contact:

Name: _____

Relationship to Contact: _____

Phone #1: _____ Phone #2: _____

Secondary Emergency Contact:

Name: _____

Relationship to Contact: _____

Phone #1: _____ Phone #2: _____

MEDICAL HISTORY

Patient Name _____ Birth Date _____

Medical Physician's name/address/phone: _____

_____ Date of last physical: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions:

Are you under a physician's care now? NO ___ YES _____

Have you ever been hospitalized or had a major operation? NO ___ YES _____

Have you ever had a serious head or neck injury? NO ___ YES _____

Are you taking any medications, pills, or drugs? NO ___ YES _____

Do you take or have you taken Phen-Fen or Redux? NO ___ YES _____

Are you on a special diet? NO ___ YES _____

Do you use tobacco? NO ___ YES _____

Do you use controlled substances? NO ___ YES _____

Are you up to date on your immunizations? NO ___ YES _____

WOMEN: Are you: Pregnant/Trying to get pregnant? _____ Nursing? _____ Taking Oral Contraceptives? _____

Are you ALLERGIC to any of the following? Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____

Local Anesthetics _____ OTHER _____NO KNOWN ALLERGIES _____

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

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

COMMENTS: _____

_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) _____ DATE _____

FOR OFFICE USE ONLY:

REVIEWED BY:_____ DATE _____

Consent for Treatment

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

1. Treatment to be Provided:
   I understand that during my course of treatment that the following care may be provided: Examinations including Oral Cancer Screening, Preventive Services, Restorations, Root Canal Therapy, Crowns, Bridges, Implants, Other.
2. Drugs and Medications:
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reactions).
3. Changes in Treatment Plan:
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

Patient signature: _____ Date: _____

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that the information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secure web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBLILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, SOTRED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Patient signature: _____ Date: _____

Consent to Treat Minor Without Parent/Legal Guardian Present

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I Give Consent To:

____ Emergency or urgent care when I cannot be reached.

____ Routine dental care, which may include, but not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any and all other treatment previously discussed and agreed upon by the parents/legal guardian.

I can be reached at the following number if there are any questions: _____

I/We _____ (parent/guardian) authorize Jo-Anne Johnson Family Dentistry to provide treatment.

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized dental care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to care. We would like to familiarize you with our office policy regarding missed appointments.

Cancellation of an Appointment:

Please be courteous and call the office promptly if you are unable to keep an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 2 business days in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely dental care.

How to Cancel Your Appointment:

To cancel your appointment, please call 603-471-6000. To reschedule your appointment, please leave the best number to reach you. We will return your call and give you the next available appointment time.

Late Cancellations:

A cancellation is considered to be “late” when a patient fails to cancel their scheduled appointment with 2 business day advance notice or cancels a Monday appointment by leaving a message over the weekend.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. Failure to be present at the time of a scheduled appointment will be recorded in your record as a "no-show."

Late Cancellation or No-Show Fees:

Please be aware that in the event of a late cancellation or a no-show, you will be charged a fee as indicated below:

- ***Missed appointment or less than 48 hours notice: $75 fee will be billed to your account***
- ***After a third missed appointment: $100 fee will be billed to your account and you may be discharged from our practice***

Patient signature: _____ Date: _____

Jo-Anne Johnson D.M.D.
FAMILY DENTISTRY
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(603) 471-6000
office@jjohnsondmd.com

Record Release Request

Patient Information (Please Print)

Name: _____ DOB: _____

Additional Family Members:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Transfer Records to:
Office Name: **Jo-Anne Johnson Family Dentistry**
Phone Number: **(603)-471-6000**
Email: **office@jjohnsondmd.com**

Previous Office Info:

Office Name: _____

Office Email: _____

Office Fax: _____

I authorize the release of my, and my family members, records to be transferred.

Patient signature: _____ Date: _____