Johnson Family Dentistry

1617 East Milham
Portage, Mi 49002
269-381-7250

Office and Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, and MasterCard. We also offer convenient payment options through Care Credit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer. It is solely your responsibility to know your dental benefits.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insurance and non-insurance patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of $50 per hour may be posted to your account if an appointment is cancelled without a 24 hour advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned Check Fee of $25.00 will be added to your account balance and is collectable.

Any accounts overdue for patient payment in excess of 60 days are subject of an interest fee of 18% per annum. A returned check fee of $25.00 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

I have read and understand this financial policy.

_____	_____	_____
Printed Name	Signature	Date

TIME 04:04 PM

DATE 2/6/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Parents last name

Guardian

Caregiver

Emg. Contact

Credit Card Payment

Prophy 1x per year

Prophy 2x per year

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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 medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If 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 ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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

Signature of Patient, Parent or Guardian:

X Date:_____

DENTAL HISTORY

What is the reason for your visit today?

Date of last dental visit? Last dental cleaning?

What was done at your last dental visit?

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

May we obtain any x-rays from your former dentist?

Former Dentists Name

Address Telephone Number

Do you have any dental problems now? If yes, please describe:

Are any of your teeth sensitive to:

Yes	No	
❑	❑	Hot or Cold?
❑	❑	Sweets?
❑	❑	Biting or Chewing?
❑	❑	Have you noticed any mouth odors or bad tastes?
❑	❑	Do you frequently get cold sores, blisters or any other oral lesions?
❑	❑	Do your gums bleed or hurt?
❑	❑	Have your parents experienced gum disease or tooth loss?
❑	❑	Have you noticed any loose teeth or change in your bite?
❑	❑	Does food tend to become caught between your teeth?

If yes, where?

Do you:

❑	❑	Clench or grind your teeth while awake or asleep?
❑	❑	Bite your lips or cheeks regularly?
❑	❑	Hold foreign objects with your teeth? (Pencils, pipes, pins, nails, fingernails)
❑	❑	Mouth breathe while awake or sleeping?
❑	❑	Have tired jaws, especially in the morning?
❑	❑	Smoke or chew tobacco? If yes, how much?

Have you ever had:

Yes	No	
❑	❑	Orthodontic treatment?
❑	❑	Oral Surgery?
❑	❑	Periodontal treatment?
❑	❑	Your teeth ground or bite adjusted?
❑	❑	A bite plate or mouth guard?
❑	❑	A serious injury to the mouth or head? If so, please describe, including cause

Have you ever experienced:

❑	❑	Clicking or popping of the jaw?
❑	❑	Pain? (joint, ear, side of face)
❑	❑	Difficulty in opening or closing the mouth?
❑	❑	Difficulty in chewing on either side of the mouth?
❑	❑	Headaches, neck aches or shoulder aches?
❑	❑	Sore muscles (neck, shoulders)?
❑	❑	Are you satisfied with the appearance of your smile?
❑	❑	Would you like to keep all of your teeth for life?

❑ ❑ Do you feel nervous about having dental treatment? If so, what is your biggest concern?

❑ ❑ Have you ever had an upsetting dental experience? If yes, please describe.

❑ ❑ Is there anything else about having dental treatment that you would like us to know? Please describe.

AUTHORIZATION / RELEASE

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge, and will notify the doctor of any change in my health or medication. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I authorize the release of my dental records to any dental/medical care provider deemed necessary for my treatment by Johnson Family Dentistry.

Patient/Guardian Signature Date