Johnson Ranch Dental

480-987-4700
530 E Hunt Hwy Suite 123
San Tan Valley, AZ 85143

PATIENT INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss ____
First Middle Last Child/ Dependent: Yes ☐ No ☐

By what name do you prefer to be called? ______________________________________

Birthday: ______________________ Social Security No: ______________________________

Address: ________________________City: ____________ State: ________Zip: _________

Mailing Address if different that above: ______________________________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: _____________

E-mail Address: _________________________ Name of Employer: _______________________

If full time student, name of school: ____

Emergency Contact Person: _________________________Relationship: ____________________

Phone: ______________________ How did you hear about our office? ____________________

RESPONSIBLE PARTY INFORMATION

Name of person responsible for account: ____
Birthday: ________________ Social Security No: __________________________________
Employer_________________________________Phone____________________________
Address/Phone (if different from above): ______________________________________
Name of Spouse: __________________Birthday: _________ Social Security No: __________
Spouse's Employer: _________________________________Phone_____________________

DENTAL INSURANCE INFORMATION

Primary Insurance Company _______________________________Effective Date: ____________
Subscriber Name: ________________________________Employer: _____________________
Social Security/ID #: _____________________________ Birthdate: ____________________
Group # / Policy #: ____
Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐
Secondary Insurance Company ______________________________Effective Date: ___________
Subscriber Name: ________________________________Employer: _____________________
Social Security/ID #: ______________________________ Birthdate: ___________________
Group # / Policy #: ____
Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ Other

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MEDICAL HISTORY

Patient Name: ______________________________________ DOB: _________ Phone: ___________________________

Physician Name: ____________________________________ Phone: ___________________________

Date of last physical exam: _________________ Are you under the care of a physician now? ☐ YES ☐NO

If yes, please explain: ____

Have you ever been hospitalized, and if so for what? ____

CHECK any of the following conditions you have or have had in the past:

- ☐Allergies
- ☐Artificial Joints
  Date of Surgery: _______
- ☐Asthma
- ☐Atrial Fibrillation
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Bruise Easily
- ☐Cancer
- ☐Chemotherapy
- ☐Chest Pain
- ☐Diabetes
- ☐Drug Addiction
- ☐Emphysema
- ☐Epilepsy or Seizures
- ☐Excessive Bleeding
- ☐Fainting/Dizzy Spells
- ☐Head Injuries
- ☐Artificial Heart Valve
- ☐Congenital Heart Defect repaired w/ prosthetic material
- ☐Heart Disease
- ☐Heart Attack
- ☐Heart Failure
- ☐Heart Murmur
- ☐Heart Pacemaker
- ☐Infective Endocarditis
- ☐Hepatitis
- ☐High Blood Pressure
- ☐HIV/AIDS
- ☐Kidney Disease
- ☐Liver Disease
- ☐Mental Disorders
- ☐Mitral Valve Prolapse
- ☐Pain in Jaw Joints
- ☐Radiation Treatment
- ☐Respiratory Problems
- ☐Rheumatic Fever
- ☐Sinus Problems
- ☐Stroke
- ☐Thyroid Disease
- ☐Tuberculosis
- ☐Venereal Disease
- ☐Other:
  ____

CIRCLE any of the following medications you are allergic to or that have caused reactions:

Aspirin Local Anesthetic (Novocain) Valium Nitrous Oxide Codeine Penicillin

Percodan Erythromycin Sulfa Amoxicillin

List any other medications that you are knowingly allergic to or have had a bad reaction to: ____

List any medications you are currently taking: __________________________________

____

Are you currently, or have you ever taking the drug Fen Phen? ☐ YES ☐ NO

Are you currently pregnant, trying to get pregnant, or nursing? ☐ YES ☐ NO

Are you currently taking Birth Control Pills? ☐ YES ☐ NO

Is there any other medical information not included above which you feel we should be informed about?

☐ YES ☐ NO

IF yes, please explain: ____

CONSENT

I acknowledge that all the above information is accurate to the best of my knowledge. I hereby authorize Johnson Ranch Dental and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Johnson Ranch Dental and/or their trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists. I have read and agree completely and wholly with all office policies including Financial, Insurance Filing, Insurance Benefits, Delinquent Accounts, Collections Proceedings, Missed Appointments, Dental Records and Privacy Practices which where provided.

____

Signature of Patient/ Parent or Guardian Date

____

Doctor Signature Date

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DENTAL HISTORY

Patient Name: ____

Reason for last visit: ___________________________ Approximate date of last dental visit: ____________________

What is your *primary concern* that you would like us to address first? _______________________________________

Has anything ever happened in *previous experiences* at the dentist that was reason not to return? Yes ☐ No ☐

If yes, please explain: ____

If we were sitting here together a year from now, what needs to happen for you to consider our office an excellent choice for you? Examples might be: Being pain free, in great dental health, having whiter teeth, no more silver fillings, cost, etc.
Please write answer. ____

What do you value more in a dental office? Please write answer below.

Cosmetic- You most value how your teeth look. Want them straight. Want them white.

Function- You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side or area. No food or drink should be off limits to you.

Comfort- You most value NOT being in pain or having any tooth or gum sensitivities. Example: I can't eat this anymore because it hurts or is sensitive.

Longevity- You most value the ability to have your natural teeth forever. You wish to have the work you have done in the chair to last as long possible.
____

What is the most important objection or obstacle you have to visiting a dental office? Please write answer below.

No objections or obstacles- I come faithfully every 6 months and value my dental health.

Fear- Of pain. Noises. Environment. Past Experiences.

Time- Tight schedule. Getting appointments to suit your schedule. Not able to take off work, etc. Getting in and out of office quickly.

Have NOT had a sense of urgency- Nothing really hurts so haven't seen need to go to dentist in years or something has been hurting at some level for a while but I've been able to live with it.

Budget- Knew I needed a lot of work, didn't have money to address any issues found.

No Trust- Felt you were told you needed treatment you didn't need. Felt ripped off. Bad previous experience. Didn't give me any data to support treatment they recommended.

____

When the Dentist or Dental Team Member needs to talk to you about options to restore your dental health (such as crowns, dentures, implants, etc.), do you prefer: Please write answer below.

1. A simplified oral explanation and explanation and description of dental treatment needed.
2. Both detailed oral and visual explanation which could include video animations, demonstrating the procedure recommended and or photographs of the procedure or photos of other patients' mouth that had similar treatment.
3. Have physical models on hand to hold and feel to aid in visualizing the work needed to be performed.

   ____

Do you prefer to break your appointments up into smaller visits and schedule out over time? _______________________

Do you prefer to get any necessary treatment done today, if possible, as getting into the office is a challenge for you?
____

____
Signature of Patient/ Parent or Guardian Date

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OFFICE POLICIES

FINANCIAL AGREEMENT

All co-payments and account balances are due in full at the time service is provided in office unless prior arrangements have been made and signed on the treatment plan. We accept cash, Visa, MasterCard, American Express, Discover, and Care Credit. Any amount of estimate not paid by insurance will be paid by patient/responsible party unless other arrangements have been previously made in writing.

INSURANCE FILING

You, the patient/responsible party, are ultimately responsible for payment in full on your account, not the insurance company. We do however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient/responsible party.

ASSIGNMENT OF INSURANCE BENEFITS

I/we hereby assign directly to Johnson Ranch Dental any insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

DELIQUENT ACCOUNTS

All delinquent accounts (30 days or older) are subject to reasonable service charges and/legal interest rates.

COLLECTION PROCEEDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

FAILED/MISSED APPOINTMENTS

Failed appointments are a significant contributor to rising health care costs. We require at least 2 business days notice to cancel an appointment. If 2 business days notice is not given, your appointment is considered a MISSED appointment. Missed appointments will be assessed a fee of $75 per hour of the missed appointment. This fee is due by the patient. After 2 missed appointments, you will be on a WALK-IN BASIS ONLY. Due to the hardship caused by repeated missed appointments, dental care may be TERMINATED and your insurance carrier will be notified.

DENTAL RECORDS

Your records can be released upon receipt of a dental records release form from the provider you wish to have your records send to. If you would like a copy of any records, there is a charge of $25.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I further understand that I have the right to refuse to sign this acknowledgment.

I authorize the release of my confidential protected dental information to only the following people:

______________________________ ______________________________

______________________________ ______________________________

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

____

Patient Name

____

Responsible Party Signature & Date