WESLEY JOHNSON, DDS

MODERN DENTISTRY • FAMILY VALUES

37624 SE FURY STREET, SUITE 200 • SNOQUALMIE • WA • 98065 • (425) 292-9230

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. ___ - ___ - ____ Birthdate ___/___/___

Mailing Address _____ Home Phone (___) ___-____

City _____ State _____ Zip Code _____

Cell (___) ___-____ Fax (___) ___-____ Email _____

How did you hear about our office?

❑ Location ❑ Postcard ❑ Referral Card ❑ Office Website ❑ Hometown Values

❑ Phonebook ❑ Sno Valley Star ❑ Insurance ❑ Internet ❑ Other _____

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate ___/___/___ Social Security No. ___ - ___ - ____

Patient Occupation _____ Employer _____ Work Phone (___) ___-____

Spouse Occupation _____ Employer _____ Work Phone (___) ___-____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
Employee's S.S. No ___ - ___ - ____	Employee's S.S. No. ___ - ___ - ____

Person responsible for payment: _____

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. (___) ___-____ Work Ph. No. (___) ___-____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment? ❑ Yes ❑ No
Have you ever had a bad dental experience? ❑ Yes ❑ No
Do you have difficulty or pain when opening (yawning)? ❑ Yes ❑ No
Does your jaw get stuck, locked or "go out"? ❑ Yes ❑ No
Difficulty / pain when chewing, talking, or using your jaws? Teeth? ❑ Yes ❑ No
Do you have noises in your jaw joints? ❑ Yes ❑ No
Pain about the ears, temples or cheeks? ❑ Yes ❑ No
Does your bite feel uncomfortable or unusual? ❑ Yes ❑ No
Have you had a recent injury to your head / jaw? ❑ Yes ❑ No

Have you been treated for a jaw joint problem? ❑ Yes ❑ No
Do your teeth ever feel loose? ❑ Yes ❑ No
Does food catch in-between your teeth? ❑ Yes ❑ No
How often do you brush?_____ Floss? _____ ❑ Yes ❑ No
Any difficulty chewing your food? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to cold / heat / etc? ❑ Yes ❑ No
Have you ever been premedicated for dental work? ❑ Yes ❑ No
Do you have frequent Headaches? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? _____

_____

_____

HEALTH HISTORY

Are you having any pain or discomfort at this time? ❑ Yes ❑ No
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you been hospitalized in the past 2 years? ❑ Yes ❑ No
Have you been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No
Physician Name _____
Address _____ Phone:_____

Are you currently taking any medications / drugs? ❑ Yes ❑ No
If yes, please list: _____
List Medications: _____

_____

_____

Women: Are you pregnant? ❑ Yes ❑ No
Please list any serious medical condition(s) that you have/had:

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Angina Pectoris	❑	❑	Sickle Cell Disease	❑	❑	Emphysema / Asthma	❑	❑	Fever Blisters / Cold Sores
❑	❑	Heart Disease / Attack / Stroke	❑	❑	Bruise Easily	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Fainting / Dizzy Spells
❑	❑	Heart Failure	❑	❑	Hemophilia	❑	❑	Arthritis / Rheumatism	❑	❑	Epilepsy / Seizures
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Cortisone Medicine	❑	❑	Hay Fever / Sinus Trouble
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Venereal Disease	❑	❑	Allergies / Hives
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Shingles
❑	❑	Heart Surgery	❑	❑	Ulcers	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Nervousness
❑	❑	Heart Pacemaker	❑	❑	Glaucoma	❑	❑	Frequent Headaches	❑	❑	Psychiatric Treatment
❑	❑	Artificial Heart Valve	❑	❑	Chemotherapy / Cancer	❑	❑	Pain in Jaw Joint	❑	❑	Drug / Alcohol Addiction
❑	❑	Diabetes	❑	❑	X-ray / Cobalt Treatment	❑	❑	Artificial Joints (Hip, Knee)			
❑	❑	Blood Transfusion / Anemia	❑	❑	Cosmetic Surgery	❑	❑	Scarlet Fever			

Are you allergic to or have you reacted adversely to the following?

❑ Antibiotics ❑ Aspirin
❑ Codeine ❑ Latex
❑ Metals / Jewelry ❑ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to Dr. Wesley Johnosn and his staff to use any photos taken for lecturing and continuing education purposes.

Signature _____ Date _____

Medical History Update
(For Office Use Only)

Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____

WESLEY JOHNSON, DDS
MODERN DENTISTRY • FAMILY VALUES

OFFICE FINANCIAL POLICY

37624 SE Fury Street, Suite 200 • Snoqualmie, WA 98065
tel (425) 292-9230 • fax (425) 292-9239

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment. Please check one of the following:

- ❒ 5% Accounting Courtesy for payment in full with cash or check.
- ❒ Visa, MasterCard, Discover
- ❒ Payment Plan

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 60 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

We are here to assist you in any way possible. Please make your questions and concerns known to our team … Our goal is to ensure that you have an outstanding experience.

Signature (responsible party) Date

Dr. Wesley Johnson
37624 Fury Street
Snoqualmie, Washington 98065
425-292-9230

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Dr. Johnson's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and Dr. Johnson's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the facility.

Dr. Johnson reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		**YES**		**NO**
SPOUSE ONLY		**YES**		**NO**
OTHER (***PLEASE SPECIFY***):		**YES**		**NO**

_____

_____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____

_____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

PROVIDED PRIOR TO TREATENT? **YES** **NO** DATE PROVIDED:

REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	UNABLE TO SIGN.	
	REASON NOT GIVEN.	
	OTHER (EXPLAIN):	