Edwina V. Johnson, DDS 4200 Hemingway Drive, Oklahoma City, OK 73118 405.557.1245

Patient Information Form

Name ______________________________ Address ____
City ____________________ State _____ Zip __________ Sex (M/F) _____ Date of Birth ____________
Home Phone ___________Work Phone ___________ Social Security No. ___________ Email _________
Marital Status ___ Name of Spouse/Significant Other ____
Employer __________________ Address ________________City ___________ State ___ Zip ________
Responsible Party: Name ____________________________ SSN _______________ DOB ___________
Name of friend or relative not living with you ________________ Address _________________________
City _______________________ State ___ Zip ________ Phone ________________________________
Referred By __________________Last Dental Appointment – Date and Reason ____________________

Medical History:

YES	NO		Does your medical history include any of the following conditions?
___	___	1.	Are you having pain or discomfort at this time? Explain ______________________________
___	___	2.	Do you feel nervous about having dental treatment?
___	___	3.	Have you had a bad experience in a dental office? Explain ___________________________
___	___	4.	Have you been a patient in a hospital in the last 2 years? Explain _____________________
___	___	5.	Are you allergic to any medications? If so, what? _________________________________
___	___	6.	Have you had any excessive bleeding?
___	___	7.	List any illnesses or diseases that you have or have had: ____________________________
___	___	8.	When you walk up the stairs, do you have shortness of breath?
___	___	9.	Do your ankles swell during the day?
___	___	10.	Have you ever had any injury to your face or jaws? Explain ___________________________
___	___	11.	Have you lost or gained more than 10 pounds in the past year?
___	___	12.	Do you ever wake up from sleep short of breath?
___	___	13.	Are you on a special diet? Explain ____
___	___	14.	Has you medical physician ever said that you have cancer or a tumor?
___	___	15.	Are you HIV positive?
___	___	16.	Do you have AIDS?
___	___	17.	Have you had Hepatitis A, Hepatitis B or Hepatitis C? (Not immunization)
___	___	18.	Do you have a heart pacemaker or other prosthetic joints or devices?
___	___	19.	Have you ever experienced an unusual reaction to anesthetic? Explain _________________
___	___	20.	Do you have difficulty chewing or opening your mouth wide?
___	___	21.	Do you have sensitive teeth, bleeding gums or sore gums?
___	___	22.	Do you ever have sores in your mouth or on your lips that heal slowly?
___	___	23.	Have you ever had rheumatic fever?
___	___	24.	Have you ever had liver disease?
___	___	25.	Have you ever had tuberculosis?
___	___	26.	Do you have a heart murmur?
___	___	27.	Have you ever had a venereal disease?
___	___	28.	Have you ever had epilepsy?
___	___	29.	Have you ever had a stroke?
___	___	30.	Have you ever had diabetes?
___	___	31.	Have you ever had high blood pressure?
___	___	32.	Are you taking any psychotropic drugs?
___	___	33.	Are you taking Fosamax?
___	___	34.	Women: Are you pregnant now?

SIGNATURE: ________________________________ DATE: ___________________

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FINANCIAL POLICY

THERE WILL BE A $35.00 SERVICE CHARGE FOR ALL RETURNED CHECKS.
THERE WILL BE A $35.00 CHARGE FOR ALL BROKEN APPOINTMENTS OR FOR CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE

EMERGENCY TREATMENT

Payment in full is expected at the completion of your emergency visit.

NON-INSURANCE PATIENTS

1. Payment in full is expected at the completion of your visit. We accept cash, checks (with identification only after first visit) and the following credit cards: VISA and MasterCard.

2. Prosthetics (crowns, bridges and dentures). Payment of 50% is expected at the time of impressions. The balance is due at the time the prosthetic device is delivered or within 30 days, whichever occurs first.

INSURANCE PATIENTS

1. Payment is expected for the uncovered portion of your treatment. We will bill your insurance company for the remainder.

2. Prosthetics (crowns, bridges and dentures). Please make payment of 50% of the total cost at the time of your impressions. We will bill your insurance company for the remainder.

3. The large number of insurance plans often causes difficulty in determining the exact amount of insurance coverage. It is not unusual for there to be either a balance due or a credit after the patient and insurance have both paid. If there is a balance, you are responsible for the full amount. If there is a credit, you will have the option of a refund or to apply the credit to future services. **You are the patient and are therefore ultimately responsible for all charges.**

4. The percentage of coverage by your insurance company may be based on the **company's own** reduced fee schedule for dental services and may be less than our charges. This will result in lower coverage for you. **We have no control over this situation.** The lower payment is a direct result of the plan selected by you or your employer. **WE CANNOT WAIVE THE CO-PAYMEN**T. We are required by all insurance companies to collect the co-payment.

5. The financial responsibility of this office is completed whenever a valid claim for service has been provided to your insurance plan. It is not the responsibility of this office to investigate the cause of any nonpayment or service denial by your insurance plan. Our business coordinator will assist you whenever possible if additional information is required by your insurance plan. However, once your plan has notified our office of a patient responsibility action with regard to the claim payment, payment will be expected within 30 days and will be subject to delinquency action beyond 60 days. If the disputed claim is ultimately paid by your plan, then a refund will be issued within 10 working days following receipt of payment.

SIGNATURE: ______________________________ DATE: _________________