Bradley E. Johnson, D.M.D
1016 NW Newport Avenue-Bend, OR 97701
Phone: (541) 389-1107
Fax: (541) 317-5958
www.ContemporaryFamilyDentistry.com

PATIENT INFORMATION

Date: _____

Patient Name: _____
FIRST MI LAST NICK NAME

Birth Date: _____ Sex: _____ Social Security #:_____

Home Address: _____ City: _____ State:_____ Zip:_____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Would you like appointment confirmation by: ☐ Email ☐ Text ☐ Phone

Employer: _____ Occupation: _____

Spouse or Parents Name: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____

Insurance Co. Phone #: _____

Insurance Co. Address: _____City:_____ State: ____ Zip: _____

Policy Holder Name: _____ Date of Birth: _____

ID Number: _____Group#:_____

Policy Holders Employer: _____

Secondary Insurance Company: _____

Insurance Co. Phone #: _____

Insurance Co. Address: _____City:_____ State: _____ Zip: _____

Policy Holder Name: _____ Date of Birth: _____

ID Number: _____Group#:_____

Policy Holders Employer: _____

PATIENT MEDICAL HISTORY

Name of last dentist visited: _____

Where was your last dentist located? _____*Date of last appointment:* _____

Does your last dentist have any recent x-rays of you? _____ Are you satisfied with your past dentistry? _____

Are you worried about receiving dental treatment? _____

Have you ever been told you have gum disease? _____ How often do you brush? _____ Floss? _____

Rate your smile 1 to 10, 10 being the best it could be: _____

Is there anything you would change about your smile?_____

CURRENT MEDICATIONS: _____

Vitamins/supplements: _____

ALLERGIES TO MEDICATIONS:_____

Do you take any medications to help you sleep? _____

Do you use tobacco? _____ Use alcohol? _____ Are you pregnant? _____

Physician's name: _____ Phone: _____ Date of last visit: _____

Are your teeth sensitive to any of the following?

_____ Hot _____ Cold _____Sweets

_____ Biting Pressure _____ Previous Injury

Please circle if you have or have had any of the following.

Abnormal Blood Pressure	Cholesterol	Hepatitis	Psychiatric Disorder
Acid Reflux	Depression	Herpes	Shortness of Breath
AIDS/HIV	Diabetes	Insomnia	Sleep Apnea
Allergies:_____	Epilepsy/Seizures	Kidney Disease	Stroke
Anemia	Emphysema/Lung Disease	Latex Allergy	Substance Abuse
Arthritis	Endocarditis	Liver Disease	Thyroid Disorder
Artificial Joint	Glaucoma	Migraines/Headaches	Venereal Disease
Asthma	Heart Ailment	Osteoporosis	
Bulimia/Anorexia	Heart Murmur	Pacemaker	Other:_____
Cancer	-Artificial Heart Valve or Stents	Prolonged Bleeding	

List Major Surgeries Date: _____ Procedure: _____
Date: _____ Procedure: _____
Date: _____ Procedure: _____

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

_____ Clench or grind teeth
_____ Clicking or gravel sounds in your jaw
_____ Gum Surgery
_____ Sore or unhealed areas in mouth
_____ Frequent and or severe headaches
_____ Pain in jaw joint ears or side of face
_____ Loose, shifted of tipped teeth
_____ Injury to face or Jaw
_____ Favor one side when chewing
_____ Swollen or bleeding gums
_____ Chronic neck or shoulder pain

Do you snore? YES NO Don't know

How likely are you to fall asleep in the following situation?

	0 **No Chance**	1 **Slight Chance**	2 **Moderate**	3 **High Chance**
• Sitting and reading	☐	☐	☐	☐
• Watching TV	☐	☐	☐	☐
• Sitting inactive in a public place (theater or meeting)	☐	☐	☐	☐
• As a passenger in a car for an hour without a break	☐	☐	☐	☐
• Lying down to rest in the afternoon when circumstance permit	☐	☐	☐	☐
• Sitting and talking to someone	☐	☐	☐	☐
• Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
• In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Score: _____
NW: _____

The medical history above is accurate and complete to date and you have my permission to discuss any portion of this medical history with my physician. Furthermore, I consent to dental treatment procedures and local anesthesia deemed necessary for dental treatment of the above named person.

_____ _____

Patient Signature *(parent's signature if patient is under 18 years)* ***Date***

OFFICE POLICIES PLEASE READ AND SIGN

FINANCIAL POLICY: I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits. Accounts assigned to collections will be charged a $50.00 collection fee. All balances over 60 days old will bear interest of 18% per annum or 1.5% per month. All returned checks will result in a $35.00 charge per check.

INSURANCE: Payment of your **estimated** percentage is due at the time of treatment. If there is a difference between what the insurance pays and the **estimate** we collected the balance is due upon receipt of your account

Continued…

statement. Insurance is gladly billed as a courtesy to patients, when you provide us with current information and any necessary forms. **All charges** are your responsibility whether or not they are covered by insurance. Insurance reimbursement is between you, your employer and the insurance carrier. **Benefits quoted by your insurance are not a guarantee of payment.** All patients are advised to contact their insurance for benefit and payment information.

PAYMENT OPTIONS: We accept cash, checks, VISA, MasterCard, American Express, Discover, CareCredit or Citi HealthCard.

APPOINTMENT POLICY: We require a minimum of a 48-hour notice to cancel or reschedule an appointment. No charges will occur when a 48-hour notice is given. Should we not hear from you at least 48 hours prior to your scheduled appointment; a charge at the following graduated scale will be made for a missed appointment, there will be a $25.00 charge for each half hour missed; $37.50 for each 45 minutes appointment, $50 or more for each hour missed. **Remember, when an appointment is scheduled this time is reserved for you**.
Please help assist us in providing the best care for our patients by complying with our appointment policy. We appreciate your understanding and cooperation.

AUTHORIZATION: I authorize Contemporary Family Dentistry to release information including diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payers and/or my other health practitioners.
I authorize and request my insurance company to pay my insurance benefits directly to the dentist or dental group. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

_____ _____

Patient Signature *(parent's signature if patient is under 18 years)* ***Date***

FOR OFFICE USE ONLY

Medical History Update

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials

_____ _____ _____
Date: Initials