Time 3:27 PM | Johnson Family Dentistry | Date 12/7/2016

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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	

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

Do you use controlled substances?	○ Yes ○ No	If yes
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	○ 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:_____

Johnson Family Dentistry Patient Registration

Patient First Name:_____ Middle Initial:___ Last Name:_____

Responsible Party (If someone other than the patient)

First Name:_____ Middle Initial:___ Last Name:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Sex:

Male __ Female __ (Please check one) Date of Birth:_____ Social Security:_____

__ Responsible Party is also a Policy Holder/ __Primary Insurance Policy Holder/ __Secondary Policy Holder (Please check one)

Patient Information

First Name:_____ Middle Initial:___ Last Name:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Sex:

Male __ Female __ (Please check one) Date of Birth:_____Social Security:_____

Employment Status: Full Time__ / Part Time__ / Retired__ (Please check one)

Primary Insurance Information:

Name of Insured:_____

Patient Relationship to Insured: Self__ / Spouse__ / Child__ / Other__

Insured Social Security:_____ Insured Date of Birth:_____

Insurance Company:_____ Insured Employer:_____

Secondary Insurance Information:

Name of Insured:_____

Patient Relationship to Insured: Self__ / Spouse__ / Child__ / Other__

Insured Social Security:_____ Insured Date of Birth:_____

Insurance Company:_____ Insured Employer:_____

Johnson Family Release of Information

Would you like for us to leave you a voicemail confirming upcoming appointments?

Yes ___ No ___ (Please check one) Phone # _____

Please list other person(s) who might answer the phone:

Name:_____ Relationship to You:_____

Name:_____ Relationship to You:_____

***Can we leave them a message about your appointment time(s), medical information, and financial information? Yes___ No ___ (Please check one)

Would you like for us to text you confirming upcoming appointments?

Yes ___ No ___ (Please check one) Name:_____

Relationship to You:_____ Phone # _____

Would you like E-mail reminders? Yes___ No ___ (Please check one)

E-mail Address:_____

*For Text/E-mail reminders I understand that the information is not sent in an encrypted manner and there is a risk it could be accessed inappropriately. I still elect to receive text/or e-mail communication. ___ (Please check) Signature:_____Date:_____

Who would you like for us to contact in case of an emergency?

Name:_____ Relationship to You:_____

Phone # _____

Would you allow us to take a picture of you for our charts? Yes___ No___ (Please check one)

Patient Rights:

-I have the right to revoke this authorization at any time.

-I may inspect or copy the protected health information to be disclosed as described in this document.

-Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

-Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

-I have the right to refuse to sign this authorization and that my treatment will not conditioned on signing.

__x_____

James Clark Johnson, Jr. DDS, PA
3606 Medical Park Court
Morehead City, NC 28557
(252) 247-0500
Fax: (252) 726-5964
www.jfdenc.com
email: office@jfdenc.com

Name(s) of Patient(s):_____
_____

Address of Patient(s):_____
_____

Date(s) of Birth:_____
_____

I hereby authorize_____(previous dentist name, city, state and phone number) to release my dental records to:

_____Dr. James Clark Johnson_____
Address:_____3606 Medical Park Court_____
_____Morehead City, NC 28557_____
Telephone:___(252) 247-0500_____

TO RESPONDING DOCTOR: PLEASE INCLUDE DATES OF LAST PANO, ANY OTHER X-RAYS AND SEALANTS WHEN APPLICABLE.

____ **CHECK HERE IF YOU DO NOT KNOW THE NAME OF YOUR PREVIOUS DENTIST**

I understand that I may revoke this consent at any time except to the extent that action has already been taken upon and that it will expire ninety days from the date below.

The doctor releasing any information is hereby relieved from all legal responsibilities or liabilities for the release of the information described above to the extent indicated and authorized herein.
Signature of Patient:_____Date:_____

JOHNSON FAMILY DENTRISTY

Local Anesthetic Consent Form

We strive to make dental care as comfortable as possible. One of the strategies we employ is the use of dental anesthetics (such as lidocaine, mepivacaine, articaine). Although the use of local anesthetics is a safe, well-established procedure to control pain, adverse reactions can occur. These reactions include, but are not limited to, the following items:

1. Rapid heartbeat – The anesthetic may make your heart race for a few minutes after the anesthetic is administered; it usually is short lived. If you have high blood pressure, please let Dr. Johnson know.
2. Fainting – can be associated with a rapid pulse, usually associated with fear.
3. Hyperventilation – This is characterized by rapid breathing, lightheadedness, tingling in the hands, and possible tightness in the chest. It is also usually associated with fear.
4. Allergic Reactions – These are extremely rare with the anesthetics we use. They can be characterized by swelling, redness, or anaphylactic reactions that involve trouble with breathing. If you have experienced an adverse reaction to an anesthetic before, please let us know.
5. Toxicity Reactions – These occur from overdose or rapid absorption of the anesthetic into your blood stream. We will never administer more anesthetic than is recommended for your body size, but, it is important to understand that everyone has a different tolerance to medications.

Complications that can arise from the use of a local anesthetic include:

1. Numbness to additional areas of the face can occur due to variations in nerve anatomy. These areas will start to feel normal after the anesthetic wears off, usually in 1 to 4 hours.
2. Paresthesia can occur when a nerve is traumatized during the administration of anesthetic. This may result in a lingering feeling of numbness or tingling, burning, or pain. Although rare, it most often occurs when numbing the lower back teeth. In most cases, the symptoms of paresthesia gradually diminish with time, but, in some rare cases they may be permanent. Unfortunately, the only alternative to avoid this risk is to have the dental work completed without anesthetic (most people accept the risk!). If you experience symptoms of paresthesia after dental work, please inform us as soon as possible because early treatment is essential for certain cases of paresthesia.
3. A "shocking" sensation can occur when the anesthetic is administered close to the nerve, it is usually short lived.
4. Hematoma – This is characterized by blood pooling outside of the blood vessels and can have the appearance of a swollen bruise. It occurs when a blood vessel is punctured during the procedure. They may be visible for up to two weeks, but will usually resolve on their own.
5. Trauma to the lips & cheeks while the anesthetized tissue is numb.
6. Jaw pain can result from the muscles around the area of the anesthetic or from holding your mouth open for an extended period of time during dental work.

Please let us know if you have had any type of allergic or adverse reaction to dental anesthetics in the past. Fortunately, complications related to the use of dental anesthetics are rare.

I consent to the use of dental anesthetics whenever Dr. Clark Johnson recommends it for dental treatment. I understand that I can certainly request not to use anesthetic for any procedure.

Patient or Guardian Signature _____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please Print Name_____

Signature_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

_____

_____

3606 Medical Park Court
Morehead City, NC 28557
252-247-0500 (office) 252-726-5964 (fax)
www.jfdenc.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address_____

Telephone_____ E-Mail:_____

Patient#:_____ Social Security #:_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: James Clark Johnson, Jr., DDS Telephone:
Phone: 252-247-0500 Fax: 252-726-5964
Address: 3606 Medicl Park Court, Morehead City, NC 28557

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date:_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____
Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Financial & Appointment Policy

Welcome to our practice! We value and appreciate the fact that you have entrusted us with your dental care. Our goal is to provide gentle, comprehensive family dentistry in a comfortable setting. To accomplish this goal and maintain a high quality level of care, we must be paid in a timely manner. To avoid any confusion, we have established the following policies regarding payment of services.

*We accept cash, personal check, money order, Visa, Master Card, or Care Credit. Checks returned for any reason will be subject to a $25 fee, and the account holder will lose check privileges with our practice.

*__Full Payment__ is expected

__Cash Discount Over $500 (For Patients Without Insurance):__ We offer a 5% discount for all treatment over $500 for which you pay in full (cash or check) at time of service.

*__Major Service – Two Payment Options:__ We offer a two-payment option for Crown, Bridge and Denture treatment. We ask that you pay-one-half of your co-payment at the first appointment and the second half at the delivery date appointment.

*__Credit Card Payment Option__: We allow (with a signed agreement form and established payment history with our office), a Credit Card Payment Option, which allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.

*__Term Loan:__ Upon approval by Care Credit, we offer our patients an interest-free term loan (up to 12 months) through Care Credit with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

*__In the Event of Divorced or Separated Parents__: The parent who brings the child into the office for treatment is responsible for payment regardless of what the divorce or separation court documents state or who the insurance policy holder is.

*As a courtesy, we will file your dental claim with your insurance company. Your deductible and co-pay or any portion not covered by your insurance company is due at the time of service. The agreement to pay for your dental care is a contract between you & your insurance carrier, and they rarely cover all costs. You are responsible for any amount that your insurance does not cover. Since we do not have a way to track your dental visits with other dentists, we are unable to maintain an accurate annual allowance for you. Please be aware of the annual maximum allowance you have with your insurance carrier when scheduling your appointments. You should be "aware" that your insurance company may not cover composite (white) fillings for posterior teeth and the additional cost will be your responsibility if you choose a composite filling.

*Accounts not settled in a timely manner will be turned over to a collection agency. The responsible party for each account will be charged any fees associated with collections, including attorney fees, court costs and late fees. Delinquent accounts will be charged interest at the rate of one percent per month.

*Broken appointments are costly and inconvenient to other patients, as well as our office. Kindly give 24 hours notice if you are unable to keep your appointment. Multiple broken appointments will lead to you and your family being dismissed from our practice. If you are more than 15 minutes late for your appointment, we may have to reschedule you for another day. We reserve the right to charge $50 for broken appointments.

We appreciate your cooperation with these policies. If you have any questions, feel free to speak to our office staff.

Signature: _____ **Date:**_____