Patient Name_____**Date**_____

Medical Physician's Name & Phone_____

Please answer the following health questions as completely as possible (circle YES or NO)

1. Do you consider yourself to be in good health? YES NO
2. Are you now or have you been under a physicians care within the past year?
   - If YES, specify condition being treated- YES NO
3. Do you take any medications, including birth control pills?
   - If YES specify name and purpose- YES NO
4. Do you have or have you ever had any heart or blood problems? YES NO
5. Have you ever been told you have a heart murmur? YES NO
6. Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? YES NO
7. Do you bleed or bruise easily? YES NO
8. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO
9. Have you ever had hepatitis or liver disease? YES NO
10. Circle if you have ever had any of the following: Rheumatic Fever Asthma Cancer Rheumatism Arthritis Tuberculosis Venereal Disease Heart Attack Kidney Disease Immune System Disease Blood Disorder Other Disease- YES NO
11. Circle if you have ever had any unusual reaction or if you are allergic to: Penicillin Aspirin Acetaminophen Ibuprofen Codeine Barbiturates Sulfa Drugs Other (explain) YES NO
12. Have you ever had a severe reaction to dental treatment or local anesthetics? YES NO
13. Are you allergic to any local anesthetics? YES NO
14. Do you have any other allergies? If YES please explain: _____ YES NO
15. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO
16. Have you ever received counseling for excessive use of alcohol and/or drugs? YES NO
17. Women: Are you pregnant? YES NO
18. How long ago did you see your last dentist? Name of previous dentist?_____
19. Do you have or have you ever had bleeding or sensitive gums? YES NO
20. Have you ever taken *Phen-Fen* or similar appetite suppressants? YES NO
    - If YES, have you seen your physician or cardiologist for a cardiac evaluation? YES NO
21. Have you taken *Bisphosphonates* such as Fosamax, Actonel, Boniva, Aredia, Zometa, Didronel or Skelid? YES NO

Snoring and Sleep Apnea Screening

Do you snore? YES NO
Do you have high blood pressure? YES NO
Has anyone reported that you choke or gasp for air while sleeping? YES NO
What is your neck size? (Inches) ___
Do you wake refreshed? YES NO
Are you excessively tired during the day? YES NO

Dental information

Are you currently in pain? YES NO
Do you have any pain in or near your ears? YES NO
Do you habitually clench your teeth during the day or night? YES NO
Do you have any present dental complaints? YES NO
Are you happy with the appearance of your teeth/gums/smile? YES NO
- If NO, what don't you like about your smile?_____

Would you like to discuss how to WHITEN your teeth? YES NO
Would you like to discuss enhancing the appearance of your smile? YES NO

Health Questionnaire Acknowledgement
&
CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointments.

I authorize Dr. Stephen F. Johansen and/or assistants, as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporarily or rarely permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I request and consent to all dental procedures which my dental conditions or those of my dependants may require, and I understand that procedures in dental surgery, diagnosis, and treatment are not an exact science and no guarantees as to the outcome of my treatments will be offered only that Dr. Stephen F. Johansen will exercise his professional expertise and ability in my best interests according to his best judgment. In consenting to any oral surgery I understand that possible hazards may include, but are not limited to: pain, swelling, bruising, infection, tingling, or numbness of the lips, tongue, gums, and/or face, loss or damage to other teeth or restorations, root or tooth into the sinus, oral antral fistula, maxillary sinusitis, possible mandibular fracture, and postoperative hemorrhage and discomfort. Adverse reactions to materials, medicines, anesthetics, and procedures are possible in dentistry, possibly resulting in, but not limited to, pulpal irritation, root canal treatment, loss of teeth, necrosis, infection, pain, anaphylactic shock, and intestinal or systemic upset, and voluntarily assume the possible risks. I consent to the fees charges for services by Dr. Stephen F. Johansen and they are satisfactory to me. In essence, I accept Dr. Stephen F. Johansen as my dentist and understand that he will exercise all his professional knowledge to the best of his ability.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

_____

Patient Signature (Parent or Legal Guardian) **Date**

I have reviewed my original health history above and certify that it is accurate except for changes indicated below:

Date	Changes	☐ None	Patient Signature	Reviewed By
Date	Changes	☐ None	Patient Signature	Reviewed By
Date	Changes	☐ None	Patient Signature	Reviewed By
Date	Changes	☐ None	Patient Signature	Reviewed By

STEPHEN JOHANSEN DENTISTRY

Who may we thank for referring you to our office? _____

Patient Information

Patients Name_____ Preferred Name_____ Male/Female

Birth Date _____ Age_____ SS# _____ Marital Status S M D O

Address _____ City/State _____ , _____ Zip _____

Home Phone _____ Employer _____ Work Phone_____

Cell or other phone _____ Email Address_____ DL#_____

Person Responsible for Account _____ Relationship _____

Birth Date _____ Age_____ SS# _____ DL#_____

Address _____ City/State _____ , _____ Zip _____

Phone _____ Employer _____ Work phone _____

In Case of an Emergency: (that does not live with you)

Name of Nearest Relative or Friend_____ Phone_____

Address _____ City / State _____ , _____ Zip _____

Primary Dental Insurance Information

Insured Name _____ ID# _____ Birth Date _____

Insurance Company_____ Group or Policy Number_____

Ins. Address _____ City / State _____ , _____ Zip _____

Insurance Phone _____ Insurance Fax (if available)_____

Employer _____ Employer Phone Number_____

Secondary Dental Insurance (complete only if covered by two insurance companies)

Insured Name _____ ID# _____ Birth Date _____

Insurance Company_____ Group or Policy Number_____

Ins. Address _____ City / State _____ , _____ Zip _____

Insurance Phone _____ Insurance Fax (if available)_____

Employer _____ Employer Phone Number_____

PAYMENT AGREEMENT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with the extension of credit, please be advised of the following policy which applies to this office. The responsible party agrees to:

Pay the doctor at the time services are rendered. I understand that Dr. Johansen will submit an insurance claim on my behalf but all charges incurred are ultimately my responsibility. A finance charge of 1.5% will be added to all accounts over 60 days old. If a collection agency is required I agree to pay collection fees, up to 40%, which will be added to my outstanding balance.

Responsible Person Signature _____ **Date** _____

THE FACTS ABOUT INSURANCE

Please understand we are desirous to extend care to you and work with you and any insurance coverage you may have.

- Professional services are rendered to the patient, and not to the insurance company. Thus the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

- Unfortunately, insurance benefits will almost always be less than anticipated. Please understand the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.

- For your convenience we will estimate the portion of your total fee that your insurance company will cover. This is only an estimate. After insurance benefits, you are responsible for any uncovered portion of total fee. I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I herby authorize release of information for insurance purposes.

- If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can pre-authorize our benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.

- A finance charge of 1.5% per month will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.

- Should collection become necessary, the responsible party agrees to pay all collection fees, up to 40% and reasonable attorney fees.

Thank you for your understanding in this matter.

Signature Date

Dr. Stephen F. Johansen, D.D.S, PC

TO OUR VALUED PATIENTS

Office Policies:

- **Patients that do not have dental insurance, payment in full is expected on the day of service. We offer zero interest financing through Care Credit.**

- **Patients with dental insurance, the responsible party will pay the patient portion and any deductible on the day of service. The insurance will be billed as a courtesy, however please be aware that if the insurance does not pay within 90 days, payment in full is expected.**

- **Patients that have a scheduled appointment and need to cancel must do so 24 hours prior to the appointment or a $75.00 cancellation fee will apply. The reason for this policy is that we do not routinely double book patients. Therefore same day cancellations do not leave us enough time to fill the appointment leaving the doctor's time open. This is particularly important with the hygienist's schedule because she is never double booked and your appointment time is specifically reserved for you. If we are to maintain a "non assembly line" dental office and continue to treat one patient at a time, it is imperative that patients keep their appointments or leave us an adequate amount of time to schedule another patient.**

- **There is a $25.00 processing fee for any returned checks.**

- **The responsible party agrees to pay all collection fees, up to 40% and all attorney fees and court costs associated with collecting for services rendered.**

- **At times photographs of dental procedures may be taken for demonstration, advertisement, patient records and insurance purposes. By signing below I allow Dr. Stephen Johansen to use any photographs of me for the aforementioned purposes. At no time will my identity be revealed without my consent.**

I HAVE READ THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM.

_____ _____

Signature **Date**