# *Welcome To The Office of Dr. Mark W. Johnson*

I would like to take this opportunity to say Welcome to the Office. I am very happy that you have chosen me as your dental provider. My staff and I are here to answer any questions you may have and assist you in making informed dental decisions.

Enclosed you will find your new patient information forms. Please fill them out as completely as possible. This will help us in determining any medical conditions that may require pre-med, allergies to any materials that might be used in our office or medication that might be prescribed to you in the case of infections and to help us determine the best possible dental treatment for you. Make sure to sign and date all the areas that are highlighted.

Let me take this opportunity to go over our office policies. We do have a 24 hour cancellation or no-show policy. We do charge a fee of $50.00 if you fail to cancel your scheduled appointment or do not show up for your scheduled appointment, unless it is an emergency. We also have a late show policy with our hygienists, We schedule our hygiene appointments according to your needs and at a specific time, if you are 5-10 minutes late our Hygienist's will try to get as much as they can get done in the allotted amount of time for your scheduled appointment. *If you arrive 15 minutes or more late for your scheduled appointment, we will need to reschedule your appointment.* Please understand that we have other patients scheduled after your appointment and they expect to be seen on time as well. We recommend that you come to your scheduled appointment 5-10 minutes early. We do try our best to accommodate your schedule with ours and it is our hope that we can work together in this area.

Thank you for choosing our office as your dental provider, if you ever have any concerns or questions feel free to contact us @ (505) 922-9511. We look forward to establishing a wonderful relationship with you. ☺

Dr. Mark W. Johnson, D.D.S. & Staff

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

**Social Security #:** _____ **Birth Date:**_____ **Email Address:** _____
Phone **(Home)**: _____ **(Work)**: _____ **(Cell)**:_____

***How would you prefer to be contacted: please check one*** ☐ ***Phone*** ☐ ***Email*** ☐ ***Text***

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____
**Do you or have you ever had Joint replacement?** _____ **If Yes, When?** _____
**Do you or have you had Heart Valve replacement?** _____ **If Yes, When?** _____
**Do you or have you ever had to pre-medicate prior to a dental visit?** _____ **If Yes, When?** _____
**Do you or have you ever had any of the following?**

**MOUTH**

| | Yes | No |
|---|---|---|
| Bleeding/sore gums…….. | ☐ | ☐ |
| Unpleasant taste/bad breath …… | ☐ | ☐ |
| Burning tongue/lips……..…. | ☐ | ☐ |
| Frequent blisters,lips/mouth…….. | ☐ | ☐ |
| Clicking/popping jaw..…… | ☐ | ☐ |
| Difficulty opening/closing jaw….. | ☐ | ☐ |
| Ortho Treatment……..….. | ☐ | ☐ |

**TEETH**

| | Yes | No |
|---|---|---|
| Loose Teeth…….…… | ☐ | ☐ |
| Sensitive to hot…….. | ☐ | ☐ |
| Sensitive to cold…..……..…. | ☐ | ☐ |
| Sensitive to sweets…..…..…. | ☐ | ☐ |
| Sensitive to biting……..…. | ☐ | ☐ |
| Clenching/grinding..……..…. | ☐ | ☐ |
| Change in bite……..…….... | ☐ | ☐ |

**Do you or have you ever had any of the following? Please check those that apply:**

☐ AIDS
☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Are You Pregnant
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ **Codeine Allergy**
☐ **Penicillin Allergy**
☐ **Sulfa Allergy**
☐ **Latex Allergy**

☐ OTHER_____

Please list medications currently taking: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Who May We Thank for Referring You? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:**_____
**Signature of patient, parent or guardian**

# Insurance Information

## Do you have insurance? Yes( ) No( ) or Self Pay( )

**(If self pay, the rest of this sheet DOES NOT need to be filled out)**

**Who carries the insurance? Yourself ( ) Spouse( ) Parent( ) Other( )**

**(Fill the next part out ONLY IF The Insurance carrier is somebody other than yourself)**

**Name of person who carries insurance:_____**

**Date of Birth:_____Social Security#:_____**

**Employer that insurance is under:_____**

**(ALL INFORMATION BELOW MUST BE FILLED OUT EVEN IF YOU, YOUR SELF ARE THE INSURANCE CARRIER)**

**Name of Insurance:_____**

**Insurance Mailing Address:**

**Member ID or Subscriber#:_____Group#:_____**

**Payor Id#:(if available)_____InsurancePhone#:_____**

**IS THERE A SECONDARY INSURANCE? YES( ) NO( )**

**Who carries the insurance? Yourself ( ) Spouse( ) Parent( ) Other( )**

**(Fill the next part out ONLY IF The Insurance carrier is somebody other than yourself)**

**Name of person who carries insurance:_____**

**Date of Birth:_____Social Security#:_____**

**Employer that insurance is under:_____**

**(ALL INFORMATION BELOW MUST BE FILLED OUT EVEN IF YOU, YOUR SELF ARE THE INSURANCE CARRIER)**

**Name of Insurance:_____**

**Insurance Mailing Address:**

**Member ID or Subscriber#:_____Group#:_____**

**Payor Id#: (if available)_____ Insurance Phone #:_____**

**Patient Signature:_____Date:_____**

**FAMILY DENTISTRY**
**MARK W. JOHNSON, D.D.S.**
**5115 COORS BLVD NW., SUITE F**
**ALBUQUERQUE, NM 87120**
**OFFICE (505) 922-9511 FAX(505)792-4480**

## Notice of Privacy Practices Ackowledgement

I understand that under the Health Insurance portability and Accountability Act of 1996 ("HIPPA"), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **notice of privacy practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **notice of privacy practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **notice of privacy practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENTS NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

I, _____ authorize this office to speak to _____,
**Print Patient's Name** **Print Authorized Person's Name**
In regard to my account or appointments.

Signature: _____ Date: _____

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Ackowledgement, but was unable to do so as documented below:

Date:_____Initials:_____Reason: _____

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Dr Mark W. Johnson D.D.S.

***Smile Evaluation***

1. Do you like the way your teeth look? Yes ☐ No ☐
   Explain:_____

2. Are you happy with the color of your teeth? Yes ☐ No ☐
   Explain:_____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐
   Explain:_____

4. Would you like your teeth to be straighter? Yes ☐ No ☐
   Explain:_____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐
   If so, where?_____

6. Would you like your teeth to be longer? Yes ☐ No ☐
   If so, Upper_____ Lower_ Both_____?

7. Do you like the shape of your teeth? Yes ☐ No ☐
   Explain:_____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐
   Explain:_____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
   Yes ☐ No ☐
   Explain:_____

10. If you could change anything about your smile, what would you change?_____
    _____