Registration

Rodney W. Johnson, DDS

Patient Name ↑ | Date of Birth ↑ | Social Security Number ↑

Home Address | City | State | Zip

Home Phone | Cell Phone | Email

Spouse or Person Responsible for Minor | Relation | Date of Birth | Social Security Number

Home Phone | Cell Phone | Email

Employed by:

Other Person Responsible for Minor | Relation | Date of Birth | Social Security Number

Home Phone | Cell Phone | Email

Employed by:

Name of Dental Insurance | Please give card(s) to receptionist. | Other Dental Insurance

Where did you hear about us?

Appointment: we see all patients on an appointment basis. We try to see everyone at their appointed times. We do appreciate your being on time and we will do our best to do the same.
Cancellations: If you cannot keep an appointment, we ask that you give us 24 hours notice, otherwise, you will be charged. In order to not keep our patients waiting, we do not double book, therefore, if you do not make your appointment, we are left idle and the charge will help to defray expenses.
Fees and Payments: All fees are expected at the time of treatment. If you are to receive extensive treatment requiring several visits, you will be given an estimate and may make financial arrangements.
Insurance: We will file your insurance claim on your behalf if furnished with the complete information at the time of the appointment; however, you are responsible for all expenses regardless of insurance. If you are not sure of coverage, ask your insurance company. If you are not sure of what our charges might be, please discuss it with us in advance. By signing this form, you authorize us to release information to concerned parties and accept payments from insurance companies in your behalf.

Please read carefully…there is a charge for broken appointments!

Signature | Date

Medical History

Have you had or do you have any of the following:

- ☐ Bleeding tendencies or blood diseases
- ☐ Complications with dental treatment
- ☐ Reactions to anesthetics or gasses
- ☐ Cancer
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Kidney Trouble
- ☐ Artificial Joints or valves
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Ear Problems
- ☐ Eye Problems
- ☐ Nasal Problems
- ☐ Hepatitis
- ☐ Abnormal Blood Pressure
- ☐ Heart-Lung Problems

Doctor's Notes:_____

List any medications you are taking:_____

List any allergies:_____

List any medical treatment in the last year:_____

Females: Are you pregnant? ☐ Yes ☐ No

List any medical conditions that you feel could affect your treatment here:_____

Your Physician's Name:_____ Tel. No.:_____
His specialty:_____
Who should we notify in case of emergency:_____
Relation:_____ Tel. No._____

Dental History

Date of last dental visit:_____ For what purpose:_____
What x-rays did you have?:_____
Any complications from previous dental treatment?:_____
Do you need replacements for missing teeth?:_____
Do your gums bleed?: ☐ Yes ☐ No Does your jaw "pop"?: ☐ Yes ☐ No
Do you "grind" your teeth?: ☐ Yes ☐ No
Do you have, in your mouth or throat, any: ☐ Swelling ☐ Sores ☐ Ulcers ☐ Loose Teeth
Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure ☐ Brushing
List any unnecessary dental treatment you have had in the past:_____
Are you unhappy with any past dental treatment?:_____
Please give a brief summary of your past dental treatment:_____
What dental treatment do you need today?_____