Stephen L. Johnson, D.D.S., P.C.

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

PATIENT INFORMATION

DATE: ____________

NAME: ______________________ (LAST / FIRST / M.I.) ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

ADDRESS: ______________________ (STREET / APT. # / CITY / STATE / ZIP)

BIRTHDATE: __________ (MO. / DAY / YR.) TELEPHONE: ☐ __________ (HOME) ☐ __________ (OFFICE)

OCCUPATION (OR SCHOOL): __________ GRADE ______ S.S.# __________

DENTAL INSURANCE CO.: __________ GROUP NO. __________

Responsible Party (if not patient) __________

Has any member of your family ever been treated in our office? ○YES ○NO Spouse's name __________

Whom may we thank for referring you to our office? __________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation ☐ Other

DENTAL HISTORY

	PLEASE CIRCLE
Do you have a specific dental problem? Describe __________	○YES ○NO
Do you have dental examinations on a routine basis? Last visit __________	○YES ○NO
Would you describe your present dental health as good? Comments __________	○YES ○NO
Do you think you have active decay or gum disease? __________	○YES ○NO
Do your gums ever bleed? Discuss __________	○YES ○NO
Do you brush and floss on a routine basis? Discuss __________	○YES ○NO
Do you feel nervous about having dental treatment? __________	○YES ○NO
Have you ever had a bad experience in a dental office? Describe __________	○YES ○NO
Do you want to keep your remaining teeth? __________	○YES ○NO
Do you like your smile? __________	○YES ○NO

Name of previous dentist (optional) __________

MEDICAL HISTORY

Height ______ Weight ______

Medical doctor's name __________

Are you under a doctor's care now? Why? __________	○YES ○NO
Have you been hospitalized during the past two years? Why? __________	○YES ○NO
Are you taking any medications, pills, or drugs? What? __________	○YES ○NO
Are you allergic to any medications or substance? What? __________	○YES ○NO
Are you pregnant? (women) __________	○YES ○NO

Please CIRCLE if you have had any of the following:

☐ Heart Trouble	☐ Chest Pain	☐ Scarlet Fever	☐ Cancer	☐ Hypoglycemia
☐ High Blood Pressure	☐ Shortness of Breath	☐ Asthma	☐ Thyroid Disease	☐ Psychiatric Care
☐ Low Blood Pressure	☐ Swelling of Feet/Ankles/Hands	☐ Hay Fever	☐ Parathyroid Disease	☐ Drug Addiction
☐ Heart Murmur	☐ Fainting or Dizziness	☐ Sinus Trouble	☐ X-ray or Cobalt Tmt.	☐ Blood Transfusion
☐ Rheumatic Fever	☐ Stroke	☐ Emphysema	☐ Chemotherapy/Radiation	☐ Hemophilia
☐ Congenital Heart Lesion	☐ Diabetes	☐ Frequent Cough	☐ Arthritis/Gout	☐ AIDS
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Lung Disease	☐ Rheumatism	☐ Venereal Disease
☐ Heart Pacemaker	☐ Artificial Joints/Hips	☐ Tuberculosis	☐ Pain in Jaw Joints	☐ Cold Sores
☐ Heart Surgery	☐ Kidney Trouble	☐ Liver Disease	☐ Cortisone Medicine	☐ Fever Blisters
☐ Blood Disease	☐ Ulcers	☐ Hepatitis A (infec.)	☐ Glaucoma	☐ Herpes
☐ Anemia	☐ Allergies	☐ Hepatitis B (serum)	☐ Epilepsy or Seizures	☐ Bruise Easily
		☐ Yellow Jaundice	☐ Nervousness	☐ Sickle Cell Anemia

Have you ever had any other serious illness not circled above? __________ ☐ YES ☐ NO

Please describe in detail __________

Do you wish to talk to the doctor privately about any problem? __________ ☐ YES ☐ NO

X __________ (PATIENT SIGNATURE (PARENT OR GUARDIAN)) Date __________

Reviewed by: Doctor __________ Date __________ B.P. __________

Dr. Stephen Johnson DDS
2249 Broadway
Grand Junction, CO 81503\241-0110

To Our Valued Patients:

In order to provide optimum care we need to know your medical status. Please update your health history. We are especially concerned if you are taking any bisphosphonate medications. Please circle any of the medications listed below that you are currently taking.

Actonel	Bonefos	Forteo (Injectable)
Aredia	Ostac	
Boniva	Skelid	
Fosamax	Didronel	None

Date________________ Signature____
Date________________ Signature____
Date________________ Signature____
Date________________ Signature____

DR. STEPHEN JOHNSON DDS
2249 Broadway
Grand Junction, CO 81503
970-241-0110

SECTION A: The Patient

Name: ____
Address: ____

Telephone: ____________________________ Email: ______________

Social Security Number: ______________________________________

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, ______________________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ___________________________________ Date: __________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________
Relationship to Individual: __________________________________

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form:

____

____

Describe the reason why the individual would not sign this form:

____

____

SIGNATURE: ____
I attest that the above information is correct.

Signature: _____________________________ Date: ______________
Print Name: ____________________________ Title: ______________

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE