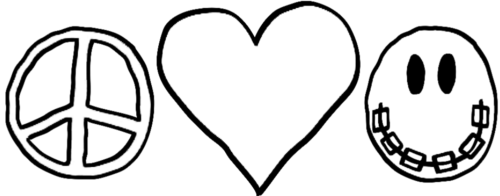
Mark A. Johnson, D.D.S., P.S.



peace • love • braces

Please complete, sign and date both sides of this form.

Patient's Name: ____
first middle last

Primary Contact Email: ____

Address: ____
street city state zip

Phone: ____
home work cell

Birthdate: ______/______/______ Social Security: ____________________

Patient's Employer: ____________________ Dental Insurance: ____________________

Father's Name: ____
first middle last

Address: ____
street city state zip

Phone: ____
home work cell

Birthdate: ______/______/______ Social Security: ____________________

Father's Employer: ____________________ Dental Insurance: ____________________

Mother's Name: ____
first middle last

Address: ____
street city state zip

Phone: ____
home work cell

Birthdate: ______/______/______ Social Security: ____________________

Mother's Employer: ____________________ Dental Insurance: ____________________

____ ____________________

Signature (Parent or Guardian if patient is a minor) Date

over

Health History

Patient's Name: ____
first middle last

Family Dentist: ____

Last check-up or cleaning within 6 months? YES NO

Family Physician: ____

Allergic Reactions (CIRCLE)

Latex Aspirin Ibuprofen Other: ______________________________

Frequently Experienced (CIRCLE)

Headaches Fainting Teeth Grinding

Vomiting Gagging TMJ Problems Other: ______________________________

Diagnosed or Treated (CIRCLE)

Arthritis Asthma Seizures Hearing Impaired **Rheumatic Fever

Head Trauma Diabetes Anemia Hepatitis **Heart Murmur

Teeth Trauma Pregnancy HIV/Aids Blood Pressure **Joint Replacement/Implants

Medications (PLEASE LIST)

1. ______________________________ Reason: ______________________________
2. ______________________________ Reason: ______________________________
3. ______________________________ Reason: ______________________________

**Does the patient require antibiotic pre-medication for dental treatment? YES NO

INSURANCE ASSIGNMENT AND RELEASE: I, the undersigned assign directly to Dr. Mark Johnson all insurance benefits, otherwise payable to me for services rendered.

I also hereby authorize Dr. Mark Johnson to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

____ ____________________

Signature (Parent or Guardian if patient is a minor) Date