Northwest SMILE CENTER

Today's Date:_____
How did you hear about us:_____

Patient Information

Name: _____
Patient Name
Address:_____
City:_____St_____Zip_____

Birth Date**:** _____
SSN**:** _____-_____-_____

Home Phone:(____)_____-_____
Work Phone: (____)_____-_____ Ext:_____
Cell Phone: (____)_____-_____

Occupation: _____
Employer: _____
Email:_____

Name of Spouse: _____
Birth Date: _____
SSN: _____-_____-_____

Cell Phone: (_____)_____-_____
Work Phone: (_____)_____-_____Ext:_____

Occupation: _____
Employer: _____
Email:_____

Emergency Contact Information

Name of relative <u>not</u> living with you:

_____
Relationship: _____
Address: _____
City:_____St_____Zip_____
Phone: (_____)_____-_____

INSURANCE INFORMATION:

Primary Coverage

Insured's Name:_____
Primary Subscriber
SSN: _____-____-_____ or ID #_____
DOB: _____
Address: _____
City_____St_____Zip_____
Home Phone: (_____) _____-_____
Employer:_____

Insurance Company: _____
Address:_____
City_____St_____Zip_____
Group No.:_____
Toll Free Phone No.: (_____) _____-

Secondary Coverage

Insured's Name: _____
Secondary Subscriber
SSN: _____-_____-_____ ID #_____
DOB:_____
Address: _____
City_____St_____Zip_____
Hm Phone: (_____) _____-_____
Employer:_____

Insurance Company: _____
Address:_____
City:_____St_____Zip_____
Group No.:_____
Toll Free Phone No.:(_____) _____-_____

Please have your Picture ID and your valid Insurance card available for copy, If you would like us to bill your insurance company for todays services.

Thank you Dr. Johnson and Staff

Northwest SMILE CENTER

Dr. Donald J. Johnson, D.D.S.
114 W. Neider Avenue
(208)667-4551

Patient Name:_____**Birth Date**:_____
Phone Number: -

DENTAL HISTORY

Reason for today's visit:_____Date of last dental exam:_____

Name of former Dentist:_____Ph ( )_____Date of last xrays:_____

Check if you've had problems with any of the following:

__Bad breath
__Bleeding gums
__Clicking or popping jaw
__Food collection between teeth
__Grinding teeth
__Loose teeth or broken fillings
__Periodontal treatment
__Sensitivity to hot/cold
__Sensitivity to pressure/biting
__Sensitivity to sweets
__Snore Loudly
__Sores or growths in your mouth
__Dry Mouth

Do you like your smile? ___Yes ___No
How often do you brush?_____X Day
How often do you floss?_____X Day Week Month Never

__Other Concerns:_____

MEDICAL HISTORY

Physician:_____Date of last physical exam:_____
Physicians Phone:_____

Check any that apply:

__Any heart problems_____
__Anemia or other blood problems
__Arthritis/Rheumatism
__Artificial Heart Valve Date_____
__Artificial Joint(s) Date_____
__Blood Disease
__CPAP Treatment
__Cancer
__Chemotherapy
__Circulatory Problems
__Daytime Tiredness
__Diabetes
__Excessive bleeding from cuts
__Epilepsy
__Head Aches or Migraines
__Heart Attack
__Heart Murmur
__Hepatitis
__HIV/AIDS
__High Blood Pressure
__Low Blood Pressure
_Kidney Disease
__Liver Disease
__Mitral Valve Prolapse
__Osteoporosis
__Pacemaker
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Sinus Problems
__Stroke
__Sleep Apnea
__Thyroid Problems
__Tobacco Habit
__Tuberculosis
__Ulcer
__Other_____

WOMEN ONLY
__Birth Control Pills
__Pregnant (Due_____)

Allergy to <u>any</u> drugs (please list)_____
Allergy to <u>any</u> anesthetics (please list)_____
List all medications you are taking _____
_____

Do you take aspirin daily?

If there are <u>ANY</u> changes in my medical history, I will notify the dentist.

Signature:_____ Date:_____

Northwest SMILE CENTER

Assignment and Release for patients with Insurance

I certify that I, and/or my dependant(s), have insurance coverage and assign directly to Dr. Donald J. Johnson, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature: _____Date:_____

Insured Patients

All Patients must sign below

In consideration of the service rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policy. I accept full financial responsibility for all charges and services.

Signature: _____Date: _____

All Patients

If patient is a minor, Parent or Guardian must sign

* Visa, MasterCard and Care Credit are accepted
* Emergencies – Full pay at time of treatment cash/credit card
* No Post Dated Checks
* Senior Citizens 60 and over 5% discount

Northwest SMILE CENTER

Dr. Donald J Johnson

114 W Neider Ave

Coeur d'Alene, ID 83815

208 667-4551

HIPPA Consent

How we collect information about you: On behalf of Northwest Smile Center; we collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that are either required by law, or necessary to process claims or other requests.

What we do NOT do with your information: Information about your financial situation and your medical/dental condition, or the treatment and care that we provide you, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend or disseminate any information about our patients or responsible financial party, that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPPA consent.

How we do use your information: Any personal information about your health or finances, including x-rays and chart notes, are only used as is reasonably necessary, to process your dental or medical claims. In addition, this information will be shared with medical or dental product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical or dental information is accurate; determine the type of medical or dental supplies or any health care services you need. And to communicate the results of tests or findings to other health care providers on your behalf.

In the event your information is requested by law enforcement for any reason, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Signed:_____ Date:_____