Denise Harburg-Johnson, D.D.S.
Family & Cosmetic Dentistry
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PATIENT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE INITIAL ___ SEX M F BIRTHDATE _____ AGE ___
STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL # _____ SOCIAL SECURITY # _____
EMPLOYER _____ ADDRESS _____
SPOUSE NAME _____ SOCIAL SECURITY # _____ BIRTHDATE _____
EMPLOYER _____ WORK PHONE _____ CELL PHONE _____

IF PATIENT IS A MINOR - PARENT OR GUARDIAN

LAST NAME _____ FIRST _____ MIDDLE INITIAL ___ SEX M F BIRTHDATE _____ AGE ___
STREET ADDRESS (if different than patient) _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL # _____ SOCIAL SECURITY # _____
EMPLOYER _____ ADDRESS _____
SPOUSE NAME _____ SOCIAL SECURITY # _____ BIRTHDATE _____
EMPLOYER _____ WORK PHONE _____

DENTAL INSURANCE

PRIMARY

EMPLOYEE NAME _____
SOCIAL SECURITY# _____ BIRTHDATE _____
EMPLOYEE/ADDRESS _____
INSURANCE COMPANY _____
INS CO. ADDRESS _____
GROUP# _____ LOCAL# _____

SECONDARY

EMPLOYEE NAME _____
SOCIAL SECURITY# _____ BIRTHDATE _____
EMPLOYEE/ADDRESS _____
INSURANCE COMPANY _____
INS CO. ADDRESS _____
GROUP# _____ LOCAL# _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health.

MEDICATIONS

ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUGS OR PILLS FOR ANY PURPOSE	YES	NO
Anticoagulants?	☐	☐
Tranquilizers?	☐	☐
Cortisone?	☐	☐
Other Medications? (Please List)	☐	☐

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	YES	NO
Local anesthetics?	☐	☐
Penicillin or other antibiotics?	☐	☐
Sulfa drugs?	☐	☐
Barbituates, sedatives or sleeping pills?	☐	☐
Aspirin?	☐	☐
Iodine?	☐	☐
Codeine or other narcotics?	☐	☐
Other medications?	☐	☐
Allergies other than drug allergies? (Please List)	☐	☐

_____

ARE THERE ANY CONDITIONS CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?

WOMEN:	YES	NO
Is there a possibility you may be pregnant?	☐	☐
Estimated delivery date?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Are you in good health?..... Height _____ Weight _____ ☐ ☐
Have there been any changes to your general health in the past year?..... ☐ ☐
Are you under the care of a physician? .....Date of last visit:_____ ☐ ☐
If so, for what are you being treated?_____ ☐ ☐
Have you had any illness, operation or been hospitalized in the past five years? ☐ ☐
_____
Do you have unhealed injuries or inflamed areas in or around your mouth,
growth or sore spots in your mouth? ..... ☐ ☐
Referred by_____

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	YES	NO	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	YES	NO	NOTES
1	Rheumatic fever?				27	Stroke?			
2	Damaged heart valves/ mitral valve prolapse?				28	Thyroid trouble?			
3	Heart murmur?				29	Diabetes?			
4	High blood pressure?				30	Low blood sugar?			
5	Low blood pressure?				31	Kidney trouble?			
6	Chest pain, angina?				32	Are you on dialysis?			
7	Heart attack(s)?				33	Swollen ankles, arthritis or joint disease?			
8	Irregular heart beat?				34	Stomach ulcers?			
9	Cardiac pacemaker?				35	Contagious diseases?			
10	Heart surgery?				36	Sexually transmitted diseases?			
11	Bronchitis, chronic cough?				37	AIDS or HIV infection?			
12	Asthma				38	Problems of the Immune system?			
13	Hayfever/Sinus problems?				39	A tumor or growth?			
14	Tuberculosis?				40	Mental health problems?			
15	Emphysema?				41	Removable dental appliances?			
16	Difficulty breathing?				42	Are you on a diet?			
17	Any other lung trouble?				43	Drugs?			
18	Do you smoke?				44	Alcohol beverages?			
19	Blood disorder such as anemia?				45	Contact lenses?			
20	Bruise easily?				46	Eye disease/glaucoma?			
21	Bleeding tendency (abnormal bleed?)				47	X-ray treatment/chemotherapy?			
22	Jaundice, hepatitis or liver disease?				48	Blood transfusion?			
23	Infection mononucleosis?				49	Pain & clicking of jaws when eating?			
24	Gallbladder trouble?				50	Malignant Hyperthermia?			
25	Fainting spells?				51	Knee or hip replacement?			
26	Convulsions, epilepsy?				52	Any other orthropedic implants?			

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my accounts, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Patient Signature (parent of child): _____ Date: _____

Dentist Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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