ERIC JOHNSON, DDS
647 CAMINO DE LOS MARES, SUITE 209
SAN CLEMENTE, CA 92673
949.493.9311 OFFICE
949.493.2618 FAX
WWW.DRERICJOHNSON.COM

ERIC JOHNSON, DDS
AESTHETIC, IMPLANT & GENERAL DENTISTRY

Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle

Address: Street, Apt. or P.O. Box # City State Zip code

Cell Phone: | Home Phone: | Work Phone:

Age: Yrs. | Birth Date: Mo. Day Year | Email Address | ( ) Male ( ) Female | ( )Married ( )Unmarried ( )Separated ( )Divorced

Social Security No: (if child, parents) | **Whom may we thank for your referral?**

Occupation: | Employer: | How long employed?

Employer Address & Phone No: | Emergency Contact and Phone No:

Responsible Party

Person responsible for bill: | Age: | Relationship to Patient: | ( ) Male ( ) Female | Social Security No: Driver's License No:

Address: Street, Apt. or P.O. Box # City State Zip code

Home Phone: | Work Phone: Ext. | Best Time to Call:

Occupation: | Employer: | How long Employed?

Employer Address & Phone No:

Insurance Information

Insured Person's Full Name | Date of Birth

Social Security Number | Relationship to Patient | Work Phone

Insurance Company Name | Group or Union Name | Group or Local Numbers

Employer's Name | Full Address of Employer

Is insured a patient? ❒Yes ❒No

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Should we experience any problem debiting your credit card and the account is not cleared within 48 hours, a $30 service charge could incur.

Signature of Responsible Party Relationship Date

ERIC JOHNSON, DDS
647 CAMINO DE LOS MARES, SUITE 209
SAN CLEMENTE, CA 92673
949.493.9311 OFFICE
949.493.2618 FAX
WWW.DRERICJOHNSON.COM

ERIC JOHNSON, DDS
AESTHETIC, IMPLANT & GENERAL DENTISTRY

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?.....❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
   _____
   _____
2. Have you been a patient in the hospital during the past five years?.....❒Yes ❒No
   If yes: for what reason?_____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?
   ❒Yes ❒No If yes, please list:_____
   _____
4. Have you taken any medicine or drugs during the past two years? If yes, please list:.....❒Yes ❒No
   _____
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?. ❒Yes ❒No
   If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? .....❒Yes ❒No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?.....❒Yes ❒No
   If yes, please explain:_____
7. Are you on a special diet?.....❒Yes ❒No
8. Check any of the following which apply in either past or present:

❒Heart (Surgery, Disease, Attack)	❒ Latex Sensitivity	❒ Tumors
❒ Chest Pain	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Congenital Heart Disease	❒ Kidney Trouble	❒ Venereal Disease
❒ Heart Murmur	❒ Diabetes	❒ A.I.D.S./H.I.V. Positive
❒ High/Low Blood Pressure	❒ Thyroid Problems	❒ Cold Sores / Fever Blisters
❒ Mitral Valve Prolapse	❒ Glaucoma	❒ Blood Transfusion
❒ Artificial Heart Valve / Pacemaker	❒ Contact Lenses	❒ Hemophilia
❒ Artificial Joints (hip, knee, etc.)	❒ Emphysema	❒ Sickle Cell Disease
❒ Bleeding Problems	❒ Chronic Cough	❒ Bruise Early
❒ Rheumatic Fever	❒ Tuberculosis	❒ Liver Disease / Yellow Jaundice
❒ Arthritis/Rheumatism	❒ Asthma	❒ Neurological Disorders
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Epilepsy or Seizures
❒ Swollen Ankles	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Stroke	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Diet (Special / Restricted)	❒ Chemotherapy	❒ Psychiatric / Psychological Care

9. Do you have any disease, condition or problem not listed? If so, please list.....❒Yes ❒No
   _____
   _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** ❒Yes ❒No
11. Do you use birth control prescriptions?.....❒Yes ❒No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____Date _____

ERIC JOHNSON, DDS
647 CAMINO DE LOS MARES, SUITE 209
SAN CLEMENTE, CA 92673
949.493.9311 OFFICE
949.493.2618 FAX
WWW.DRERICJOHNSON.COM

ERIC JOHNSON, DDS
AESTHETIC, IMPLANT & GENERAL DENTISTRY

DENTAL HISTORY

1. What is the reason for your visit today?_____
_____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
_____
4. Previous Dentist's Name_____
Address/State/Zip_____
Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other lesions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? ....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
16. Is there anything else you would like us to know? Please describe. _____
_____
_____