Garland & Johnson Dental

321 N. Breiel Blvd.
Middletown, OH 45042
513-424-3971

2309 Woodman Dr.
Kettering, OH 45420
937-252-9070

9684 Cincinnati Columbus Rd.
Cincinnati, OH 45241
513-777-5369

PATIENT WELCOME FORM

Welcome to your new dental home. The information on this form is important for our records and for your health. This information is strictly confidential. Thank you.

PERSONAL INFORMATION

Patient's Legal Name: Last, First Initial________________ Date of Birth __________ ❒Male ❒Female

Preferred Name ________________ Home Phone #__________ Cell Phone #__________

Patient's Address: Street, Apt #________________ City__________ State__________ Postal Code __________

E-mail ________________ ❒Minor Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

If Student, name of School/College ________________ City __________ State __________ ❒Full-time ❒Part-time

Patient/Guardian's Employer________________ Occupation ________________

Work Address: Street, Ste #________________ City__________ State__________ Postal Code__________ Phone # __________

Spouse's Name: Last, First Initial________________ Spouse's Employer__________ Occupation __________

Spouse's Work Address________________ City__________ State__________ Postal Code__________ Phone # __________

Do you have other family members who are patients here? ________________

Who can we thank for referring you to our office?________________

EMERGENCY CONTACT INFORMATION

Name________________ Relationship ________________

Home Phone #________________ Work Phone #________________ Cell Phone #________________

RESPONSIBLE PARTY

Name of person responsible for this account ________________ Relationship ________________

Address: Street, Ste #________________ City__________ State__________ Postal Code__________ Phone #__________

Home Phone #________________ Work Phone #________________ Cell Phone #________________

INSURANCE AND FINANCIAL INFORMATION

Do you have insurance coverage? ❒No ❒Yes - Insurance Company Name________________ Phone #__________

Insured Name ________________ SS#__________ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate__________ Group Cert/ID #__________ Division #__________ Group/Policy #__________

Employer (if different from above)________________ Employer Address ________________

Do you have secondary coverage? ❒No ❒Yes - Insurance Company Name ________________ Phone #__________

Insured Name ________________ SS#__________ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate __________ Group Cert/ID #__________ Division #__________ Group/Policy #__________

Employer (if different from above)________________ Employer Address________________

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PATIENT WELCOME FORM

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RELEASE INFORMATION

You may discuss my health care with____

Health Care Providers ❐ Yes ❐ No Insurance Companies ❐ Yes ❐ No Others (Spouse, Parents, etc.)____________________

____

ASSIGNMENT AND RELEASE

Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a ‘pay-all’. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.

We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days notice, in which case no cancellation fee will be applied.

I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been approved. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I hereby authorize payment directly to GARLAND & JOHNSON DENTAL for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature Patient/Guardian____ Date ____________________________

Witness Signature____ Date ____________________________

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DENTAL / MEDICAL HISTORY

Former Dentist ______________________________ City, State ________________________ Last Dental visit date ____________
Date of last Oral X-rays _____________ How often do you floss? ________________ How often do you brush? ____________

Check all that apply:

Bad Breath	❒Yes ❒No	Loose teeth or broken filling	❒Yes ❒No	Sensitivity to sweets	❒Yes ❒No
Bleeding gums	❒Yes ❒No	Orthodontic Treatment	❒Yes ❒No	Sensitivity when biting	❒Yes ❒No
Blisters on lip/mouth	❒Yes ❒No	Pain around ear	❒Yes ❒No	Frequent headaches	❒Yes ❒No
Fingernail biting	❒Yes ❒No	Periodontal Treatment	❒Yes ❒No	Jaw, head or neck injuries	❒Yes ❒No
Grinding teeth	❒Yes ❒No	Sensitivity to cold	❒Yes ❒No	Jaw clicking and/or pain	❒Yes ❒No
Lip and cheek biting	❒Yes ❒No	Sensitivity to heat	❒Yes ❒No	Tooth pain	❒Yes ❒No

Physician's Name ____ Date of last visit ________________________

1. Are you currently under medical treatment?
2. Have you ever had any serious illnesses or operations?
3. Are you currently taken medications?
Please list your medications: ____________________
____
4. Do you smoke? ❒Yes ❒No
5. Do you use cocaine or other illicit drugs? ❒Yes ❒No
6. Do you wear contact lenses? ❒Yes ❒No
7. (Women only) Are you:
   - Pregnant ❒Yes ❒No
   - Nursing ❒Yes ❒No
   - Taking birth control ❒Yes ❒No

8. Have you had any allergic reactions to the following:

Local Anesthetics	❒Yes ❒No
Penicillin or other Antibiotics	❒Yes ❒No
Sulfa Drugs	❒Yes ❒No
Barbiturates (sleeping pills)	❒Yes ❒No
Sedatives	❒Yes ❒No
Iodine	❒Yes ❒No
Aspirin	❒Yes ❒No
Latex	❒Yes ❒No

Other: ____
____

Check all that apply:

AIDS	❒Yes ❒No	Diabetes	❒Yes ❒No	Nervous Problems	❒Yes ❒No
Anemia	❒Yes ❒No	Emphysema	❒Yes ❒No	Pacemaker	❒Yes ❒No
Arthritis	❒Yes ❒No	Epilepsy	❒Yes ❒No	Psychiatric care	❒Yes ❒No
Artificial Heart Valves	❒Yes ❒No	Fainting/Dizzy	❒Yes ❒No	Radiation	❒Yes ❒No
Artificial Joints	❒Yes ❒No	Glaucoma	❒Yes ❒No	Respiratory	❒Yes ❒No
Asthma	❒Yes ❒No	Headaches	❒Yes ❒No	Rheumatic Fever	❒Yes ❒No
Back Problems	❒Yes ❒No	Heart Murmur	❒Yes ❒No	Scarlet Fever	❒Yes ❒No
Bleeding abnormally,	❒Yes ❒No	Heart Problems	❒Yes ❒No	Shortness of breath	❒Yes ❒No
with surgery/extractions	❒Yes ❒No	Hepatitis	❒Yes ❒No	Sinus Trouble	❒Yes ❒No
Blood Disease	❒Yes ❒No	Herpes	❒Yes ❒No	Skin Rash	❒Yes ❒No
Cancer	❒Yes ❒No	High Blood Pressure	❒Yes ❒No	Stroke	❒Yes ❒No
Chemical Dependency	❒Yes ❒No	HIV Positive	❒Yes ❒No	Swelling of feet/ankles	❒Yes ❒No
Chemotherapy	❒Yes ❒No	Jaundice	❒Yes ❒No	Swollen Neck Glands	❒Yes ❒No
Chronic Fatigue Synd.	❒Yes ❒No	Jaw Pain	❒Yes ❒No	Thyroid Problems	❒Yes ❒No
Circulatory problems	❒Yes ❒No	Kidney Disease	❒Yes ❒No	Tonsillitis	❒Yes ❒No
Congenital Heart Issues	❒Yes ❒No	Liver Disease	❒Yes ❒No	Tuberculosis	❒Yes ❒No
Cortisone Treatment	❒Yes ❒No	Low Blood Pressure	❒Yes ❒No	Tumor/growth on head	❒Yes ❒No
Cough-persistent	❒Yes ❒No	Mitral Valve Prolapse	❒Yes ❒No	Ulcer	❒Yes ❒No
				Venereal Disease	

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Signature Patient/Guardian ____ Date ____________________________

Witness Signature ____ Date ____________________________

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DENTAL POLICY

Thank you for choosing us for your dental needs! We are committed to providing you with excellent care and convenient financial arrangements. Please read and initial the following:

INSURANCE: ________

Our office is committed to helping our patients maximize their dental benefits. We are available to answer most of your questions about your coverage; however, your policy is a contract between you and your dental insurance company. We are only able to provide you with an estimated co-pay which is due at the time of service. As a service to our patients, we will bill the insurance company and allow them 45 days to render payment. After 60 days it becomes your responsibility to pay the balance in full. Insurance policies vary; therefore we can not guarantee coverage or the amount to be covered due to the complexities of insurance contracts. Please understand that some insurance policies cover posterior white (tooth colored) fillings and/or crowns at a reduced (silver, amalgam, etc.) rate which could result in a different co-pay. We do not offer treatment based strictly on your insurance, but rather what we feel is best for our patients' overall health and care.

PAYMENT OPTION: ________

We accept the following methods of payment: cash, check, MasterCard, Visa, and CareCredit. We also offer payment plans through CareCredit. Payment in full is due at the time of service unless prior arrangements have been made.

SERVICE CHARGES: ________

The policy of this office is to charge $15 a month late fee for all accounts over 90 days past due. We charge $30 for returned checks. Additional fees may apply for excessive balances.

MISSED APPOINTMENTS: ________

Please remember that once an appointment has been made, it is a specific time reserved for you. We reserve the right to charge a $25.00 fee for all cancelled or missed appointments without a 24 hour notice.

TREATMENT TO BE DONE: ________

Our primary mission is to deliver the best and most comprehensive dental care available. Please understand that during treatment it may be necessary to change and/or add procedures because of conditions found during treatment that were not evident during the initial examination. A full treatment plan will be given to you upon comprehensive exam completion. If you choose not to do the treatment that has been suggested to you, you may be asked to sign a refusal statement. Please note that if treatment is not completed within a reasonable time, treatment may change as well.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: ________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. A copy of this HIPAA Compliance Form is available upon request.

Signature Patient/Guardian____ Date ____________________________

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PATIENT PAYMENT POLICY

In order to keep dental cost down, we request that patients pay their copay as services are rendered unless other arrangements have been made with the business office.

INSURANCE

Our practice is committed to you by providing you with the highest quality of dental care available. Our fees are determined by the actual cost of treatment not the insurance companies arbitrary determination of USUAL AND CUSTOMARY RATES.

As a courtesy to you, we submit all insurance claims and obtain the dental benefits you and your family are eligible to receive through your insurance carrier. However, this is only an estimation of coverage. Your insurance policy is a contract between you and your insurance company, we are not a party to that contract, therefore, the balance of your account is your responsibility regardless of what your insurance company reimburses for services rendered.

CO-PAYS

- We require your DEDUCTIBLE and ESTIMATED CO-PAY paid at the TIME OF SERVICE.
- We cannot bill an insurance company for any claim unless all information is received from the patient.
- We request insurance information and patient history be updated annually. If your insurance company has not paid it's estimated portion within sixty (60) days the amount outstanding will be transferred to your account and will become your responsibility.

IF SUFFICIENT INSURANCE INFORMATION IS NOT RECEIVED, THE ENTIRE FEE FOR SERVICES RENDERED WILL BE DUE AT THE TIME OF THE APPOINTMENT.

BROKEN APPOINTMENTS

We understand that occasionally situations may arise to warrant a broken appointment. However, this can leave a serious void in our schedule. We request 24 hours notice so that this time can be used for another patient in need of treatment. Therefore, WE RESERVE THE RIGHT TO CHARGE FOR AN APPOINTMENT CANCELLED OR BROKEN WITHOUT A 24 HOUR ADVANCED NOTICE. THERE WILL BE A $25.00 CANCELLED OR BROKEN APPOINTMENT FEE FOR MISSED APPOINTMENTS.

Our goal is to make your dental appointments as comfortable and as pleasant as possible, if you have any questions, suggestions or concerns, please feel free to discuss them with any of our office staff.

**I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. In the event that the account would be sent to a collection agency or attorney due to non-payment on the account, I am responsible for all collection fees or charges.

I understand by signing this form, the insurance company will release checks to the office. I also understand that the office submits claims electronically.

Signature Patient/Guardian____Date________________________________