SAN DIEGO

DENTURE & IMPLANT SPECIALISTS

Patient Medical History

Date: _____/_____/_____

Patient's Name: _____

The reason for your visit today: _____

_____

Have you been hospitalized in the past two years? Yes No

Have you been treated by a physician in the past year? Yes No
Physician's Name: _____

Have you taken any prescribed medications or drugs in the past two years?
Yes No

Please list all medications or drugs:

_____

_____

Are you, or have you ever been on any weight reduction medication
(e.g. Fen-Phen)? Yes No

Do you smoke tobacco or chew tobacco? Yes No

Have you ever had problems with a dental local or general anesthetic?
Yes No

Circle if you are allergic to any of the following medications:

Penicillin	Sulfa	Antibiotics	Codeine
Iodine	Aspirin	Latex Gloves	Local Anesthetics

Other: _____

Are you allergic (i.e. itching, rash, swelling) to or made sick by any drugs,
medications or doctor's treatment? Yes No
Explain: _____

Circle if you have or have ever had any of the following:

Heart Disease	**Stroke**	**Glaucoma**
Heart Attack	**Kidney Trouble**	**Pain in Jaw Joints**
Angina	**Ulcers**	**Allergies or Hives**
High Blood Pressure	**Emphysema**	**Hepatitis**
Low Blood Pressure	**Tuberculosis (TB)**	**Liver Disease**
Heart Murmur	**Asthma**	**Yellow Jaundice**
Mitral Valve Prolapse	**Hay Fever**	**Drug or Alcohol Addiction**
Rheumatic Fever	**AIDS or HIV infection**	**Blood Transfusion**
Scarlet Fever	**Diabetes**	**Hemophilia**
Artificial Heart Valve	**Thyroid Disease**	**Venereal Disease**
Heart Pacemaker	**Leukemia**	**Epilepsy or Seizures**
Congenital Heart Defects	**Cortisone Medication**	**Nervousness**
Heart Surgery	**Radiation Treatment**	**Sickle Cell Disease**
Prosthetic Joint	**Chemotherapy**	**Bruise Easily**
Anemia	**Arthritis**	**Psychiatric Treatment**
Rheumatism	**Prosthetic Joint**	**Fainting or Dizzy Spells**
Sinus Trouble	**Cancer**	**Lupus**

Do you have any disease(s) and/or conditions not listed? **Yes** **No**

Women:	**Are you pregnant?**	**Yes**	**No**
	Do you anticipate becoming pregnant?	**Yes**	**No**
	Are you taking birth control medication?	**Yes**	**No**

To the best of my knowledge, all of the preceding answers are true and correct. If any changes occur pertaining to my health or if my medications change, I will inform Dr. Peter F. Johnson at the next appointment.

Patient's Signature	Doctor's Signature	Date

The Office of Dr. Peter F. Johnson

Patient Registration Form:

Today's Date_____

Name_____ Home Phone_____
Last First

Address_____ Business Phone_____
Number Street

City/St_____ Zip Code_____ Cell Phone_____

Occupation_____ Email Address_____

Date of Birth_____ Sex: M F Social Security Number_____

Name of Spouse_____

Closest Relative/ Emergency Contact_____ Phone_____

If you are completing this form for another person, what is your relationship to this person?

Who may we thank for referring you to our office?

Release for Treatment:

I authorize DR. JOHNSON and any other agents or employees as selected by them to treat me. This treatment may require the administration of local anesthetics (EXCEPT for _____, which I am allergic to). Although these anesthetics are used for my benefit, they may occasionally cause inflammation, allergic reaction, pain, nerve damage because of anatomic variations, fainting and high and/or low blood pressure.

I also authorize DR. JOHNSON to photograph me for use in educational and teaching purposes.

Signature:_____Date:_____

Print Name:_____

Insurance Information:

Name of insured Subscriber: _____

Relation to patient: Self _____ Spouse _____ Other _____

Address: _____
Street and Apartment Number

City: _____ State: _____ Zip Code: _____

Home phone: (___) _____ Business phone: (___) _____

SS#: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
Month Day Year

Employer: _____

Primary Dental Insurance:

Company _____ Insurance Phone#: (___) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip:_____ ID#_____

Secondary Insurance:

Subscriber's Name:_____SSN_____ _____ _____

Company _____ Insurance Phone #: (___) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip:_____ ID#_____

I authorize the release of information relating to this claim. The dental office will pre-determine the insurance benefit for treatment, and will submit dental insurance forms as a courtesy to our patients. Insurance payments will be made directly to the insured. I understand that I am responsible for all costs of treatment, and that payment is due and payable according to financial agreements made with this office.

Signature: _____ Date:_____

San Diego Denture & Implant Specialists
Peter F. Johnson, DMD

HIPPA Consent and Acknowledgement Form

I, _____ do hereby consent and acknowledge my
Patient or Guardian
agreement to the terms set forth in the *HIPPA INFORMATION FORM* and any subsequent changes in the office policy.

I understand this consent and acknowledgment shall remain in force indefinitely.

Peter F. Johnson, DMD

HIPAA Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. Additonal information is available a by calling the U. S. Department of Health and Human Services or at: **www.hhs.gov.**

For this reason, our practice has adopted the following policies:

(1) Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, as is necessary and appropriate for your care. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

(2) It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

(3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

(4) The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

(5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

(6) Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.

(7) The practice agrees to provide the patient with access to their records in accordance with state law.

(8) The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

(9) You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, the practice is under no obligation to alter internal policies to conform with your request.

(10) There is no patient right to litigation under HIPAA.