**Marc G Johnson, DDS, PLLC**
*Oral and Implant Surgery*
*373 White Spruce Blvd*
*Rochester, NY 14623*
*585-413-0132*

You are scheduled to have a procedure with IV (moderate) or Nitrous Oxide sedation. It is **IMPORTANT** to follow these instructions so that your procedure can be done promptly, properly, and safely. Failure to follow these instructions will lead to **CANCELLATION** of the procedure.

1. **DO NOT EAT OR DRINK (EVEN WATER) FOR 6-8 HOURS** before your appointment. If you take prescription medication for a heart condition, high blood pressure, infection or other illness, and are advised by your doctor to continue your medications, then take it with a small sip of water.
2. You **MUST BE ACCOMPANIED** by a responsible adult. This person may wait in the waiting area or if leaving, make sure to leave name and number to be reached at with front office staff. You will not be able to drive a car, walk or ride in a cab or bus by yourself after the procedure. Make arrangements for someone to stay with you at home the day of your SEDATION.
3. Please wear a loose fitting short-sleeved shirt.
4. Please do not wear lipstick, blush, jewelry, acrylic nails or nail polish. It will have to be removed, so that our monitoring instruments will work properly.
5. Patients under 18 years of age **must** be accompanied by a **parent or guardian** or a designated responsible adult with a **TREATMENT CONSENT FORM SIGNED BY A PARENT OR LEGAL GUARDIAN.**
6. Please brush your teeth several times the day before surgery and at least once on the day of the procedure to help decrease the chance of infection.
7. Please arrive 15 minutes prior to your appointment.

**ADDTITIONAL INFORMATION:**

We will make every effort to insure your treatment begins at the scheduled time; however, there are occasions when a procedure may be delayed. **We will devote the same time and attention to your care as we did to the patient before you, to ensure the safe completion of your treatment.**

# Patient Information

Last Name: _____ First Name: _____ Middle Initial: ____

Preferred Name: _____ Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

Phone: *Home*_____ *Cell* _____*Work* _____

Emergency Contact: _____*Relation*_____ *Phone*_____

Your Dentist _____

Referring Dentist/Specialist (if different than above) _____

Name of person who referred you if other than Dentist/Specialist_____

Orthodontist (if applicable) _____

Medical Doctor _____

**Person Responsible for Payment of Fees:**

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Relationship to Patient: _____

Street Address: _____

City _____ State _____ Zip Code _____

Phone: *Home* _____*Cell* _____

## Insurance Information:

***Dental Insurance:*** _____Policy Holder: _____

Relationship to Patient: _____ Policy # _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Social security #: _____ Date of Birth: _____

Employer: _____ Insurance Company address: _____

**Medical and Dental History**

Patient Name: _____ Date of Birth: _____ Age_____ Gender _____

Why have you been referred to our office?

_____

List ALL medications and supplements you are taking:

_____

_____

Do you have any allergies? (please list ALL allergies including medications and latex):

_____

_____

## Please circle any of the following conditions/diseases you have had, or are now treated for:

| | | | | | |
|---|---|---|---|---|---|
| *Heart disease* | *Rheumatic fever* | *Emphysema* | *Tuberculosis* | *Alcoholism* | *Reflux* |
| *Heart attack* | *Diabetes* | *Liver Disease* | *Cancer* | *Drug Abuse* | *Anxiety* |
| *Angina* | *Hepatitis* | *Kidney disease* | *Bleeding* | *Seizures* | *Fainting* |
| *Heart murmur* | *Thyroid Disease* | *Arthritis* | *HIV* | *Anemia* | *Depression* |
| *High blood pressure* | *Asthma* | *Stomach ulcers* | *Migraines* | *Sleep Apnea* | *Sinus issues* |

**Other:**

_____

**Name and Location of Pharmacy:**_____

**Please answer the following questions:**

1. Do you have any artificial joints, heart valves, or blood vessel grafts? yes no

2. Have you ever received radiation therapy? yes no

3. Have you ever received chemotherapy? yes no

4. Do you smoke? yes no

5. Do you drink alcohol? yes (daily weekly rarely) no

6. Do you receive regular, professional dental care? yes no

7. Have you taken steroid medications within the past 2 years? yes (for: _____) no

8. Do you grind or clench your teeth? yes no

9.Do you have a known suspected or suspected TMJ disorder? yes (treatment: _____) no

10.Women: Are you pregnant or breast feeding? yes no

***The above information is true and accurate to the best of my knowledge***

Patient signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

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## Notice of Privacy Practices

**This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information.**
***Please review it carefully.***

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a set of federal laws and guidelines that requires that all health care records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

As required by HIPAA, this is an explanation of how we are required to maintain the privacy of your health your health information and how we may use and disclose your health information.

Marc G Johnson, DDS, PLLC, Oral and Implant Surgery may use and disclose your health care information only for each of the following purposes:

- **Treatment;** providing, coordinating, or managing healthcare and related services by one or more healthcare providers.
- **Payment;** activities such as obtaining reimbursement for services, confirming insurance coverage, billing or collection activities, and utilities review.
- **Health Care Operations;** the business activities of running Marc G Johnson, DDS, PLLC, Oral and Implant Surgery.

Marc G Johnson, DDS, PLLC Oral and Implant Surgery, may also create and disclose healthcare information using your individual identifiable information by removing all references to individually identifiable information.

Marc G Johnson, DDS, PLLC Oral and Implant Surgery may, without your consent, use or disclose protected health information to carry out treatment, payment, and health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as is reasonably possible after the delivery of such treatment
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to do so in a timely fashion commensurate with the urgency of your treatment needs.
- If we attempt to obtain your consent but cannot do so due to substantial barriers in communication with you, and we determine that your consent to receive treatment is clearly inferred from the circumstances.

Marc G Johnson, DDS, PLLC, Oral and Implant Surgery may contact you to provide appointment reminders or information about your treatment or account management.

I hereby authorize contact regarding appointment confirmation and other office management matters using telephone voicemail, and will authorize and permit leaving voice messages.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by your request except to the extent that we have already taken actions relying on your prior authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office manager:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to other family members, other relatives, close personal friends, or any other person indentified by you. We are, however, not required to agree with all requested restrictions. If we do not agree to a restriction, we are still required to abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information by alternative means and at alternative locations. The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- A right to obtain a copy of this notice from us upon request.

Marc G Johnson, DDS, PLLC Oral and Implant Surgery is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal responsibilities and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2012. Marc G Johnson, DDS, PLLC, Oral and Implant Surgery is required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post a current policy, and you may request a current Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal and written complaint with the Department of Health of Health and Human Services.

The US Department of Health and Human Services

Office of Civil Rights
200 Independence Ave. S.W.
Washington, DC 20201
202.619.0257
877.696.6775

***Patient Name (print): _____dob: _____***

***Patient Signature: _____ Date _____***
*(Parent or legal guardian if patient is a minor or is unable to provide legal consent)*

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This document explains our policies regarding the financial aspect of your care and how your medical and/or dental insurance will apply to your account. This document explains our policies regarding the financial aspect of your care financial agreements other than those detailed below will need to be discussed and approved by our office manager prior to seeing Dr. Johnson.

**All fees are due and payable in full when services are performed unless other specific arrangements have been made prior to treatment. A finance charge of 18% annually will be added to any account that is 30 days or more overdue. Accounts will be turned over to a collection service if over 90 days past due. Any accounts turned over to collection service will have an additional collection fee (50% of account balance) added prior to turning the account over to the collection service.**

Payment can be made in cash, your personal check, money order, visa, or mastercard.

**For our patients with insurance:**
Please understand that insurance companies generally offer several different policies in a given geographic area. The patient/guarantor is liable for knowing the specifics of their policy.
Our office participates with several local insurance carriers. We abide by, but do not control, the fee structure and general policies that these companies require for participation and to maintain provider credentialing. All co-payments and "non-covered" amounts (for non-covered services, services that exceed the patients yearly maximum coverage, and contrast specific exclusions) will be due and payable in full on the day services are performed.
For our patients who have policies with companies we do not participate with: Accepting insurance will be determined on case/patient specific basis. For those cases where insurance is accepted, benefits will be assigned to be paid directly to *Dr. Johnson DDS, PLLC.* You will be required to pay the patient's portion in full when services are performed. We may be able to provide a relatively accurate estimate of coverage on the basis of experience with our carrier policy. Determining a patient portion figure most accurately will require a predetermination of coverage claim sent prior to treatment. Following treatment and payment of patient portion you will be provided with a claim with all necessary information completed so that you can submit the claim for services yourself. In such cases, the policy holder will be paid covered amounts directly by the insurance carrier.

**AGREEMENT AKNOWLEDGEMENT:**

**Patient (or guarantor) signature: _____ Date:_____**