roller+johnson FAMILY DENTISTRY
3615 Brambleton Ave. SW
Roanoke, VA 24018
540-772-9373 p • 540-772-0408 f
www.RollerJohnsonDentistry.com
www.facebook.com/rjdentistry

First Name: Last Name: Middle Initial:

Patient is: ❍ Policy Holder ❍ Responsible Party Preferred Name:

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via email.

Birth Date: Social Security: Driver's License:

Sex: ❍ Male ❍ Female Marital Status: ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Employed By: Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Address: City: State: Zip:

Person to Contact in Case of Emergency: Phone:

Pref. Dentist: ❍ Roller ❍ Johnson Pref. Hygienist.: Pref. Pharmacy/Location:

Responsible Party
(if someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Driver's License:

❍ Responsible Party is also a Policy Holder ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Employed By: Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Address: City: State: Zip:

PRIMARY Dental Insurance

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Insurance Company:

Address:

City: State: Zip:

Insurance ID Number:

Group Number:

Group Name:

SECONDARY Dental Insurance

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Insurance Company:

Address:

City: State: Zip:

Insurance ID Number:

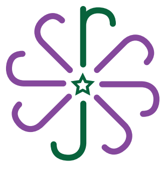
Group Number:

Group Name:

Whom may we thank for referring you to our office?

❍ Website ❍ Facebook ❍ Insurance ❍ Other ❍ Friend or Family Member Name

— Please See Other Side —



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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Question			
Are you under a physician's care now?	❍ Yes	❍ No	If yes, please explain: ______
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If yes, please explain: ______
Do you use tobacco?	❍ Yes	❍ No	If yes, please explain: ______
Do you use controlled substances?	❍ Yes	❍ No	If yes, please explain: ______
Are you taking any medications, pills or drugs?	❍ Yes	❍ No	If yes, please explain: ______

Women: Are You

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Allergies:

Are you allergic to any of the following: ❍ Asprin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Other: ______

If yes, please explain: ______

Do you have, or have you had, any of the following:

Condition			Condition			Condition		
AIDS/HIV Positive	❍ Yes	❍ No	Drug Addiction	❍ Yes	❍ No	High/Low Blood Pressure	❍ Yes	❍ No
Alcohol Addiction	❍ Yes	❍ No	Easily Winded	❍ Yes	❍ No	Hypoglycemia	❍ Yes	❍ No
Alzheimer's Disease	❍ Yes	❍ No	Emphysema	❍ Yes	❍ No	Irregular Heartbeat	❍ Yes	❍ No
Anaphylaxis	❍ Yes	❍ No	Epilepsy or Seizures	❍ Yes	❍ No	Kidney Problems/Dialysis	❍ Yes	❍ No
Anemia	❍ Yes	❍ No	Excessive Bleeding	❍ Yes	❍ No	Leukemia	❍ Yes	❍ No
Angina	❍ Yes	❍ No	Excessive Thirst	❍ Yes	❍ No	Liver Disease	❍ Yes	❍ No
Arthritis/Gout	❍ Yes	❍ No	Fainting Spells/Dizziness	❍ Yes	❍ No	Mitral Valve Prolapse	❍ Yes	❍ No
Artificial Heart Valve	❍ Yes	❍ No	Fen Phen, Redux Treatment	❍ Yes	❍ No	Radiation Treatments	❍ Yes	❍ No
Artificial Joint	❍ Yes	❍ No	Frequent Cough	❍ Yes	❍ No	Recent Weight Loss	❍ Yes	❍ No
Asthma	❍ Yes	❍ No	Frequent Headaches	❍ Yes	❍ No	Rheumatic Fever	❍ Yes	❍ No
Blood Disease, Disorder	❍ Yes	❍ No	Genital Herpes	❍ Yes	❍ No	Shingles	❍ Yes	❍ No
Breathing/Lung Problems	❍ Yes	❍ No	Glaucoma	❍ Yes	❍ No	Sinus Trouble	❍ Yes	❍ No
Cancer	❍ Yes	❍ No	Hay Fever	❍ Yes	❍ No	Stomach/Intestinal Disease	❍ Yes	❍ No
Chemotherapy	❍ Yes	❍ No	Heart Attack/Failure/Disease	❍ Yes	❍ No	Stroke	❍ Yes	❍ No
Chest Pains	❍ Yes	❍ No	Heart Murmur	❍ Yes	❍ No	Thyroid Disease	❍ Yes	❍ No
Cold Sores/Fever Blisters	❍ Yes	❍ No	Heart Pacemaker	❍ Yes	❍ No	Tuberculosis	❍ Yes	❍ No
Congenital Heart Disorder	❍ Yes	❍ No	Hemophilia	❍ Yes	❍ No	Tumors or Growths	❍ Yes	❍ No
Convulsions	❍ Yes	❍ No	Hepatitis A, B or C	❍ Yes	❍ No	Ulcers	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No	Herpes	❍ Yes	❍ No			

Comments: ______

______

______

______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

______ Signature of Patient, Parent, or Guardian ______ Date

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Financial Agreement

Payment is due at the time of treatment. We can accept cash, checks and major credit cards. We also have a payment plan called CareCredit[SM]; this plan allows you to start treatment today and spread payments over time.

Payment Options:

Please indicate below which form of payment you choose to use: (check one)

❍ Cash or Check ❍ Major Credit Card ❍ CareCredit*

Applying for CareCredit only takes a few minutes and there is no fee to apply.

**CareCredit is subject to credit approval. If credit application is declined, another form of payment listed above is required.*

I authorize and request my insurance company (if applicable) to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event I have to cancel or reschedule my appointment, I agree to give the office 24 hour notice. If not, I agree to pay a broken appointment fee. Payment is due at time of service, and any balance not paid at the time will incur a monthly service charge of 1.5%. If the dentist hires an outside attorney or collection agency to collect any unpaid balance, I agree to pay to pay an attorney's fee or collection agency's fee of 33% of the principle balance.

Signature of Patient/Responsible Party ______________________ Date ____________

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Consent to Use and Disclosure of Protected Health Information

Use & Disclosure of Your Protected Health Information

Your protected health information will be used by **Roller & Johnson Family Dentistry** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care or operations of the practice.

Notice of Privacy Policy

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Roller & Johnson Family Dentistry may or may not agree to restrict the use or disclosure of your protected health information.

If **Roller & Johnson Family Dentistry** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Roller & Johnson Family Dentistry reserves the right to modify the privacy practices outlined in the notice.

Signature

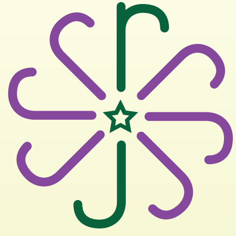
I have reviewed this consent form and the Privacy Policy and give my permission to **Roller & Johnson Family Dentistry** to use and disclose my health information in accordance with it.

____

Signature of Patient or Personal Representative

________________________________ ________________________

Witness Date



roller + johnson
FAMILY DENTISTRY

TAKE OUR...

Smile Assessment

AND SEE IF YOU MIGHT BE A CANDIDATE FOR AN ENHANCED SMILE

YES	NO	
❑	❑	Are you happy with the appearance of your teeth?
❑	❑	Are you comfortable showing your teeth when you smile?
❑	❑	Do you have unsightly crowns or fillings?
❑	❑	Do you feel your teeth are too long or too short?
❑	❑	Do you like the color of your teeth?
❑	❑	Are you interested in replacing missing teeth?
❑	❑	Are you familiar with the benefits of dental implants?
❑	❑	Are your teeth sensitive to hot or cold?
❑	❑	Are your gums receding?
❑	❑	Do you clench or grind your teeth?
❑	❑	Do you have pain in your jaw joints?

What is holding you back from your perfect smile?

- ❑ Fear
- ❑ Time
- ❑ Cost
- ❑ Other:______________________________

Name: ______________________________ Date: ______________

If you are a new patient:

Name of previous dentist: ______________________________

What was the date of your last dental exam?: ______________________________