Dr. David Johnson
PEDIATRIC DENTISTRY

Childs Information

Childs Name_____

Birth Date _____Sex_____

Home # _____

Address _____

City _____

State & Zip_____

Referred by_____

Who accompanied child today?_____

Parent/Guardian Information

Name_____

Birth Date_____ Social Security # _____

Mobile #_____Email _____

Spouse's Name _____

Birth Date_____ Social Security # _____

Mobile #_____Email _____

Financial/Insurance Information

Policy Holder _____Relation_____

Birth Date _____Social Security # _____

Insurance Company_____

Subscriber ID #_____Group # _____

Employer _____Work #_____

My mobile number_____ _____ (Please initial)

I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes .

Insurance Release/Office Policy

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. Dr. David Johnson only estimates the insurance co-payment. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for the payment. I also assume responsibility to inform Dr. David Johnson of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize release of any information, including diagnosis and records of any treatments or examinations rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or companies or any other agency necessary for the collection of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled. This authorization is considered to be effective for present and all future insurance claims and supersedes all prior arrangement signed.

I acknowledge that I have received a copy of the Privacy Policy. I agree to disclose to the dentist names of the individuals with whom I authorize the dentist to discuss my dental care.. I also acknowledge I have received a copy of the missed appointment policy. I agree with the 48 hour notice to make changed to my appointment or I will be charged $25 per half hour.

Signature _____Date _____

Health History

Has your child every been hospitalized within the past year? Yes No

Has your child had any surgeries? Yes No

Physicians name_____ phone #_____

Is your child currently taking any medications? Yes No

Specify _____

Does your child have or has your child ever had:

Oral Habits (thumb sucking, nail Biting, etc.) Yes No

Orthodontics Yes No

Grinding or clenching teeth Yes No

Frequent toothaches Yes No

Does your child brush teeth unassisted? Yes No

Is your child currently use fluoride supplements? Yes No

How has your child's dental experience been? Good Average Poor

Has your child ever had the following?

Heart Murmur Yes No
Heart Surgery Yes No
Rheumatic Heart Disease or Fever Yes No
Other heart conditions Yes No
Pre Medication required? Yes No
Allergies: Drug (antibiotics, sulfa drugs, etc..) Yes No
Food Yes No
Local Anesthetic (novacaine, etc.) Yes No
Latex Yes No
Other Yes No

Specify:

_____
_____
_____

Asthma Yes No
Respiratory Disease Yes No
Abnormal Bleeding Yes No
Transfusion Yes No
Date of transfusion _____
Epilepsy spells or seizures Yes No
Joint replacement Yes No
Diabetes Yes No
Radiation or chemotherapy Yes No
Liver or Kidney disease (specify) Yes No
A Physical or Mental Disability Yes No
Attention deficit disorder or hyperactivity Yes No

Please Explain any Yes Answers _____
_____
_____

Please list any other medical problems or information not previously mentioned

_____
_____
_____

Informed Consent & Consent to Proceed

I authorize Dr. David Johnson or his assistants as he may designate to perform those procedures as may be deemed necessary to advisable to maintain the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful, both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. After lengthy appointments, jaw muscle may also be sore or tender. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

- We are a fee for service practice. Payment is due at the time of service.
- Insured patients are expected to pay their deductible and the percentage co-payments at the time of service.
- In the event of default in the payments, a service charge of 15% (28% annual rate) on the unpaid balance will be assessed.
- I/We agree to pay all attorneys, court costs, filling fees, and all collection costs, up to 40% of the amount owing may be assessed on any collection agency retained to pursue the matter. A $25 charge will be assessed on any returned checks.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or ward during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company 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 the payment of all services rendered on my dependents behalf.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby do abide by these conditions outlined herein.

Signature_____ Dare _____