Chart # _____

JOHNSON CITY PEDIATRIC DENTISTRY

Welcome to our office! Please fill out this form completely in ink.

Child's Name _____ Birthdate _____ Sex F M
Last First MI

Child's Social Security # _____ Name Child Goes By _____

Hobbies/Pets _____

Child's Home Address _____ Mailing Address _____

City _____ State _____ Zip _____ Phone _____

School _____ Grade _____

Name and ages of other children in family _____

With whom does the child live? _____

Parent or Guardian Information _____Mother ____Stepmother ____ Guardian

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone _____

SS# _____ Cell# _____

Marital Status _____ Email Address _____

Parent or Guardian Information _____Father ____Stepfather ____ Guardian

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone _____

SS# _____ Cell# _____

Marital Status _____ Email Address _____

Who told you about our office? _____

Method of Payment

____ Check or cash at time of treatment ____ Bank Card ____ MasterCard ____ Visa

____ Insurance - Plus co-payment at time of treatment

____ Virginia Medicaid # _____

____ TennCare # _____

Primary Dental Insurance

Insured's name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group ID# _____

Insurance Co. Phone # _____ Insured's ID# _____

Financial Policy

Fees for dental services rendered are due on the date of treatment. Our office, as a courtesy to you, will file for insurance benefits for treatment rendered. On all visits, you will be responsible for any **deductibles, co-payments, or balances not covered by your insurance.** All account balances which have not been paid within 30 days becomes the responsibility of the parent/guardian. There will be a $25.00 charge on all returned checks. Further in the event this account is referred to an attorney or collection agency, the undersigned agrees to pay reasonable attorney's fees, but in not case less than $100.00 or collection fees and court costs as permitted by laws governing these transactions.

Signature of Parent/Guardian: _____ Date: _____

CHILD'S MEDICAL AND DENTAL HISTORY

Name of child's pediatrician or physician _____ Phone: _____

Has your child been hospitalized since birth? ____ Yes ____ No If yes, explain _____

_____

Is your child allergic to any medicine or foods? ____ Yes ____ No If yes, explain _____

Is your child presently taking any medication? ____ Yes ____ No If yes, explain

Has your child ever had any of the following:

NO	YES		NO	YES	
____	____	Seasonal Allergy	____	____	Tuberculosis
____	____	Asthma	____	____	Blood Disease
____	____	Anemia	____	____	Cancer/Tumors
____	____	Hepatitis	____	____	Stomach/Kidney Problems
____	____	Abnormal Bleeding	____	____	Liver Problems
____	____	Diabetes	____	____	Convulsions/Epilepsy
____	____	Handicap/Disabilities	____	____	HIV/AIDS
____	____	Mental Retardation	____	____	Ear Problems
____	____	Downs Syndrome	____	____	Cerebral Palsy
____	____	Autism	____	____	Speech/Vision Problems
____	____	Heart Condition	____	____	Hyperactivity/ADD/ADHD
____	____	Premedication needed	____	____	Mental/Emotional Disorder
____	____	Nose/Throat Disorder	____	____	Latex Allergy
____	____	Lung Disorder	____	____	Skin Disorder
____	____	Cystic Fibrosis	____	____	Other

Please explain any medical problems that your child has: _____

_____

Is this your child's first visit to the dentist? ____ Yes ____ No

If not, please give date of last dental care: _____ Previous Dentist _____

Is your child on a bottle? ____ Yes ____ No If no, at what age was it discontinued? _____

Is your primary source of water from a well? ____ Yes ____ No

Has your child had any type of injury to his/her teeth? ____ Yes ____ No

Please explain: _____

Is your child in dental pain today? ____ Yes ____ No

Please explain: _____

Does your child have a dental condition about which you are especially concerned? ____ Yes ____ No

Please explain: _____

AUTHORIZATION & RELEASE

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian _____ Date _____

JOHNSON CITY
PEDIATRIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____