

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: _____

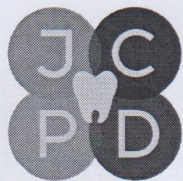
Does your child have a dental condition about which you are especially concerned? Yes No

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 _____



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)