

Patient Information

Name of Minor/Child _____ Date _____

Nickname _____ Sex M F Age _____ Birthday _____

Home Address _____

Person financially responsible _____

Home Phone _____ Work Phone _____ Cell Phone _____

Whom may we thank for referring you? _____

Insurance

Father's/Guardian's Name _____

Mother's/Guardian's Name _____

Address (if different from patients) _____

Address (if different from patients) _____

Home Phone _____ Work Phone _____
(if different from above)

Home Phone _____ Work Phone _____
(if different from above)

Employer _____

Employer _____

SS# _____ Birthday _____

SS# _____ Birthday _____

Do you have dental insurance coverage for minor/child?
_____ Yes _____ No

Do you have dental insurance coverage for minor/child?
_____ Yes _____ No

Plan Name _____

Plan Name _____

Phone Number _____

Phone Number _____

Address _____

Address _____

Group # _____ Policy # _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? _____ Yes _____ No Child's Medical Assistance ID# _____

Dental History

Date of last visit to a dentist? _____ For what service? _____

Has child complained about dental problems? YES NO Is fluoride taken in any form? YES NO

Does child brush teeth daily? YES NO Any injuries to mouth, teeth, head? YES NO

Does child use floss everyday? YES NO Any unhappy dental experiences? YES NO

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? YES NO

Medical History

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child user care of physician now?	YES	NO	Medications _____
Receiving any medication or drugs?	YES	NO	_____
Ever been hospitalized?	YES	NO	_____
Ever had surgery?	YES	NO	Allergies _____
Is there excessive bleeding when cut?	YES	NO	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK

___ AIDS/HIV	___ Anemia	___ Asthma	___ Bladder Problems	___ Cancer
___ Cerebral Palsy	___ Chicken Pox	___ Convulsions	___ Diabetes	___ Drug/Alcohol Abuse
___ Epilepsy	___ Fainting	___ Hearing Problems	___ Heart Problems	___ Hepatitis
___ Kidney Disease	___ Liver Disease	___ Measles	___ Mononucleosis	___ Mumps
___ Rheumatic Fever	___ Sinus Problems	___ Thyroid Disease	___ Tuberculosis	___ Other

Emergency Contact

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian

Date

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian

Date

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physical certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Steven R. Johnson, D.D.S.
4322 Ravensworth Road
Annandale, VA 22003

703-256-5870/Phone
703-256-5396/Fax

Financial Responsibility Agreement

Dr. Johnson and associates make every effort to keep the cost of your care down. We ask our patients to pay for treatment at the time service is rendered. To assist you in making payment we accept cash, checks, Visa, MasterCard, American Express, and Discover. We encourage our patients to keep a credit card number on record to take care of residual balances (see area below).

If you have insurance we are happy to file a claim on your behalf. Your insurance is a contract between you, your employer, and the insurance company. If you have questions concerning your insurance plan please contact your employer's human resource department or your insurance company directly.

It is the patient's responsibility to know which benefits are covered or not covered by their insurance. The patient/guardian is responsible for all co-payments, deductibles, and fees that are denied or non-covered. Any balance pending with insurance more than 90 days will be due by the patient. If there is an additional balance after the insurance company payment is received the balance is due by the patient within 30 days.

The parent or guardian that brings a minor in for treatment is the financially responsible party. Financial arrangements between individual parental parties does not absolve the parent bringing the minor from their financial obligation to our practice.

If timely payment is not made the services of an attorney, collection agency, or small claims court may be utilized. The cost of additional collection liabilities will be assessed to the patient's account.

We have a \$34.00 return check fee.

In order to contain cost and avoid raising our fees we wish to eliminate billing. Please help by providing us with the following:

Credit Card Number _____ Expires _____

Do you want to be notified before we run card for balance on account? _____

Patient's Name: _____

Parent/Guardian Name: _____
(if patient is a minor)

Patient Signature: _____