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_____

Address (if different from patients) _____

_____

Home Phone _____Work Phone_____
(if different from above)

Employer_____

SS#_____ Birthday_____

Do you have dental insurance coverage for minor/child?
_____Yes _____No

Plan Name_____

Phone Number_____

Address _____

_____

Group #_____ Policy #_____

Mother's/Guardian's Name _____

Address (if different from patients) _____

_____

Home Phone _____Work Phone_____
(if different from above)

Employer_____

SS#_____ Birthday_____

Do you have dental insurance coverage for minor/child?
_____Yes _____No

Plan Name_____

Phone Number_____

Address _____

_____

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,			pacificer, 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 herby authorize the dentist re 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 relaying 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. *Full payment is due at the time of service (i.e. co-pays, deductibles, or full fee). To assist you in making payment we accept cash, checks, Visa, MasterCard, American Express, and Discover.

We are not contracted with all insurance plans but we are happy to file a claim on your behalf. If you have a plan we are not contracted with, we will verify benefits for you and you can decide if you wish to continue with us. 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 then 90 days will be due by the patient. If there is an additional balance after the insurance company payment is received the payment is due by the patient within 30 days.

The parent or guardian that brings a minor in for treatment is the financially responsible party. A financial arrangement 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. Copy of radiographs is a $38.00 fee.

It is the policy of this office for the courtesy of our patients who want Saturday appointments, if a patient Breaks or Cancels a Saturday appointment, with less than 24 Hour Notice the patient will not have the opportunity to schedule a Saturday appointment with our office for one year.
There will be a $35 missed appointment fee if we are not given 24 hours notice to cancel.

Patient's Name (PRINTED):_____

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

Patient or Parent or Guardian Signature:_____ Date _____