Patient Information

Child's Name: ______________________________
Date of Birth: _____/_____/_____ Age: __________
Male Female

Child's Home Address: ______________________________
____
City____________________State_____Zip_______
Phone (___) ____________________

Whom does the child live with?
Mother Father Other:_________
Who has legal custody of the child?
Mother Father Other:_________

Person Responsible for Account

Person responsible for payment on this account:
Name: _________________Relation:_______________
Billing Address:______________________________
City_____________________State______Zip_______
Home Phone_______________ Cell________________

Who is responsible for making appointments?
Name: ______________________________
Mother Father Other:____________

Emergency Contact:
Name: __________________Relationship:___________
Home#: _________________Cell#:_______________

Parent/Guardian Information

Mother's Information: Mother Step Mother Guardian
Name: ______________________________
DOB:_____/_____/_____ SSN: ____________________
Address: ______________________________
City___________________State_______Zip_________
Home#:________________Cell#:___________________
Email: ______________________________
Employer/Occupation: __________________________
Work #: __________________

Father's Information: Father Step Father Guardian
Name: ______________________________
DOB:_____/_____/_____ SSN: ____________________
Address: ______________________________
City___________________State_______Zip_________
Home#:________________Cell#:___________________
Email: ______________________________
Employer/Occupation: __________________________
Work #: __________________

Parent's Marital Status: Single Married Partnered
Divorced Separated Widowed

Dental Insurance

Primary Dental Insurance

Policy Holder's Name:____________________________
DOB: _____/_____/_____ SSN: ____________________
Insurance Company:______________________________
Employer: ______________________________
Group #______________________________
Subscriber ID#_____________________________

Secondary Dental Insurance

Policy Holder's Name:____________________________
DOB: _____/_____/_____ SSN: ____________________
Insurance Company:______________________________
Employer: ______________________________
Group #______________________________
Subscriber ID#_____________________________

Medical History

Name of child's Pediatrician: ______________________________Phone#:______________
Name of child's previous Dentist: ___________________________Phone#:______________
YES NO Are your child's immunizations up to date
YES NO Is your child currently taking any medications? ______________________________
YES NO Allergies: ______________________________

Please check if your child has been diagnosed or treated for any of the following:

AIDS/HIV	Diabetes	Hepatitis	Tuberculosis	Mental Delays
Anemia	Epilepsy/Seizures	Kidney disease	Congenital birth defects	Physical Delays
Asthma	Excessive Bleeding	Liver Disease	Cerebral Palsy	Social Delays
Blood Disorder	Headaches	Rheumatic Fever	Cleft lip/ palate	Speech/Hearing
Cancer/Tumors	Heart condition	Stomach/GI disease	Frequent infections	Other

Please elaborate on all checked items: ______________________________
____

Patient has never been diagnosed with any of the above conditions

I agree that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Pediatric Dentistry of West Sacramento of any changes to my information and my child's medical status.

____
Parent Signature Date

OFFICE POLICIES

We appreciate you for allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding we offer these explanations of our office policies

CONSENT FOR DENTAL TREATMENT:

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Paul A. Johnson and his staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Johnson. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Johnson will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

Signature: ____ **Date:** ____________________________

FINANCIAL POLICY:

I________________________________ authorize Pediatric Dentistry of West Sacramento, to provide insurance carriers with any medical information necessary to process insurance claims. I hereby assign all payments from my insurance company for all services rendered to my child, to Pediatric Dentistry of West Sacramento.

Payment for services is due in full by cash, check, or charge card at each appointment at the time services are rendered. As a courtesy, not an obligation, we file your dental insurance for you. All services not covered by your insurance are your responsibility and will be billed to you. We accept Visa, MasterCard, American Express and Discover. A charge of $35.00 will be assessed on checks returned for any reason.

All accounts **60** days past due will be turned over to a Collection Agency.

I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of Pediatric Dentistry of West Sacramento.

I agree to pay all cost of collections including but not limited to 35% collection fees and attorney fees of 35% but not less than $200.00, regardless whether or not suit is filed.

All emergency treatment must be paid in full at the time services are rendered. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" of $250.00 is due at the time of service.

I have read and understand my financial obligation to Pediatric Dentistry of West Sacramento.

Signature of Responsible Party: ______________________________________ **Date:** _____________

CANCELATION POLICY:

Pediatric Dentistry of West Sacramento has a strict 24 hour cancellation policy in the event that you miss your scheduled dental appointment. We understand that unforeseeable circumstances occur and sometimes require missing an appointment. However, if you do miss an appointment without notifying 24 hours before your scheduled appointment, a **$25.00** fee will be applied to all missed Recall Appointments and a **$50.00** fee will be applied to all missed Restorative Appointments. If more than 2 scheduled appointments are missed we will no longer be able to provide dental services to your child. This policy is to protect dental appointment times for your child and other children that need care.

I have read and understand Pediatric Dentistry of West Sacramento's Cancellation Policy.

Parent's Signature ____ **Date:** ____________________________

We appreciate you for choosing Pediatric Dentistry of West Sacramento for your child's dental care. We look forward to years of close association with you as we work together to maintain your child's oral health.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Patient Name: ___________________________________

I, _________________________________ have received a copy of Pediatric Dentistry of West Sacramento's Notice of Privacy Practice with an effective date of March 28, 2012.

____

Signature of Parent/Guardian | Relationship to Patient | Date:

____

Printed Name of Witness | Signature of Witness | Date:

I, ______________________________ authorize Pediatric Dentistry of West Sacramento to release my child's personal health information to the following individual(s): (I understand I may change this list at any time).

Please print clearly:

___________________________ Relationship to Patient: _____________________________

___________________________ Relationship to Patient: _____________________________

___________________________ Relationship to Patient: _____________________________

Effective date: _____________________________this will expire on _____________________