Jordan Landing Pediatric Dentistry

Patient Information

Date_____

Name of child/minor_____
Last Name First Name MI

Sex: Male Female Date of birth ____/____/____ Age: _____ Nickname: _____

Nearest Relative not living with you _____
Name Phone Relationship

Parent/Guardian Information (Person Signing Today)

Parent/Legal Guardian _____ SSN _____
Last name First Name MI

Relationship to Patient _____ Date of Birth ____/____/____

Home Phone_____ Cell Phone _____ Other _____

Address_____
Street City State Zip

Dental Insurance Information

Policy Holder's Name _____ SSN _____
Last Name First Name MI

Insurance Company _____ Date of Birth ___/___/___

Insurance Company Phone # _____ Policy # _____

Group #_____ Relationship to Patient Self Parent Other _____

Secondary Dental Insurance Information

Policy Holder's Name _____ SSN _____
Last Name First Name MI

Insurance Company _____ Date of Birth ___/___/___

Insurance Company Phone # _____ Policy # _____

Group #_____ Relationship to Patient Self Parent Other _____

Please let us know how you found out about us! ☺

Patient Dental Office Yellow Pages Flier Advertisement Insurance Company Banner Other

Name of Referral _____

Dental History

Patient's Name _____

Date of last dental visit_____

Has your child complained about dental problems? Y N

Does your child brush their teeth daily? Y N

Does your child use floss daily? Y N

Is fluoride taken in any form? Y N

Any history of injuries to the mouth? Y N

Any unhappy dental experiences? Y N

Any mouth habits: Thumb sucking, Nail biting, Pacifier, Mouth breathing, Sleeping with a bottle, etc. Y N

If yes, please describe habit _____

Medical History

Child's physician _____ City/State_____ Phone _____

Date of Last Physical Examination _____ Results _____

Is your child under the care of a physician now? Y N

Has your child ever been hospitalized Y N

Has your child ever had surgery? Please list surgeries _____

Is your child taking any medications (including over the counter)? Please list if any _____

Does your child have any allergies to any drugs/medications? Y N Please list allergies _____

Does your child bleed excessively when cut? Y N

Has your child ever had nay of the following? (please circle all that apply)

1. Anemia	9. Steroid Treatments	17. Eye Problems	25. Scarlet Fever
2. Rheumatoid Arthritis	10. Persistent Cough	18. High Blood Pressure	26. Shortness of Breath
3. Congenital Heart Defects	11. Coughing Up Blood	19. HIV/AIDS	27. Skin Rash
4. Heart Murmur	12. Diabetes	20. VP Shunt	28. Kidney Disease
5. Other Heart Problems	13. Seizures	21. Bleeding Problems	29. Hepatitis
6. Asthma	14. Cancer	22. Rheumatic Fever	30. Liver Disease
7. Respiratory Disease	15. Radiation Therapy	23. Tonsillitis	31. Tuberculosis
8. Developmental Delay	16. Chemotherapy	24. Cold Sores	

Please explain any that have been circled above _____

_____

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 of Dr. Ryan Johansen to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____ Date _____

I understand and agree to the following:

I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present and future services rendered by Dr. Ryan Johansen and his staff to me, my family or other individuals I may have authorized. I recognize that insurance is a contract between the patient and the insurance company and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to Dr. Johansen. I will pay all sums that are due and payable at the time of services. No oral agreements have been made and this agreement cannot be modified orally. I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the outstanding balance.

Signature of Parent/Guardian _____ Date _____

Consent for Treatment

Patient Name _____

Parent/Guardian _____

Treatment:

I hereby authorize and request the performance upon my minor/child or patient, as referred to above, of the following dental services: Examination, Restorative Fillings, Pulp Treatment, Crowns, Cleanings, Fluoride Treatments to be performed by Dr. Ryan Johansen DDS, a licensed practitioner in the specialty of pediatric dentistry/pedodontics, as well as his trained dental personnel and associates. I further authorize the use of topical and local anesthetics with or without the use of Nitrous Oxide (laughing gas) as described on the back of this consent form.

I acknowledge that the dentist has explained or will explain the patient's condition, the nature and purpose of the proposed dental care, as well as alternative treatment(s). I also acknowledge that the dentist, if applicable, has explained any proposed anesthesia care or invasive monitoring as well as the risks, benefits, and alternatives associated with them. I also understand that the proposed care may involve possibilities of complications and that certain complications have been known to occur during or following the treatment to which I am consenting; even when the utmost care, judgment, and skill are used. I hereby accept the risk of these complications and the possibility of harm, if any, in hope of obtaining the desired and beneficial results of described dental/health care.

I recognize during the course of the procedure(s), unforeseen conditions may require additional and/or different treatment procedures than those explained. I, therefore, authorize and request that the patient's dentist perform such procedures as, in his professional judgment, are necessary and desirable for the patient's welfare knowing that these alterations in treatment plan will be fully explained to me after the procedure is complete.

Appointments:

I agree to make my child available for regular six month recare visits and necessary dental treatment during regular office hours and to schedule appointments until necessary treatment is complete. I understand that if I don't pay the necessary fees and/or fail to keep more than two appointments my child may be dismissed as a patient from this practice. If dismissal from this practice occurs I will be given the name of another qualified pediatric dentist to continue the care of my child. Furthermore, I agree to give 24 hours notice if an appointment must be changed or canceled. If I fail to give proper notice for my child, I agree to pay a $50.00 cancellation fee.

Behavior Management: (See reverse side)

I hereby state that I have read and understand the information on the back of this consent form, and that all questions about behavior management will be or have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions which may arise at any time during the course of my minor/child's treatment. I understand that, Dr. Ryan Johansen DDS, will not use passive restraint as defined on the back of this consent form without my expressed consent and will likely ask for my assistance with this passive restraint.

Records:

I further consent to the taking of dental radiographs (x-rays), Photographs, and dental impressions when they are indicated for the purpose of diagnosing and planning treatment, and expressly agree that, Dr. Ryan Johansen DDS, may use such materials for educational purposes including seminar instruction, publication of literature, and demonstration of methods and techniques of pediatric dentistry. I understand that strict measures will be taken to maintain my child's anonymity, and that Dr. Ryan Johansen DDS, will obtain verbal permission before using any of the above records for said educational purposes. I understand that all original dental records are the property of, Dr. Ryan Johansen DDS, PC, and cannot be taken or sent from his office. Copies of records will not be given or sent to another dental practitioner or physician without express written authorizations and release from the patient's parent/guardian under guidelines set forth by the HIPPA, enforced on April 15, 2003. I understand that I can have copies of these records made available to me within the guidelines set forth by the HIPPA.

Signature of Parent/Guardian to the above _____ Date ____/____/____

Witness _____ Date ____/____/____

NOTICE OF PRIVACY PRACTICES

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

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA") IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY, ARE KEPT PROPERLY CONFIDENTIAL. THIS ACT GIVES YOU, THE PATIENT SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. "HIPPA" PROVIDES PENALTIES FOR COVERED ENTITES THAT MISUSE PERSONAL HEALTH INFORMATION.

AS REQUIRED BY "HIPPA", WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

WE MAY USE AND DISCLOSE YOUR MEDICAL RECORDS ONLY FOR EACH OF THE FOLLOWING PURPOSES: TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

- TREATMENT MEANS PROVIDING, COORDINATING, OR MANAGING HEALTH CARE AND RELATED SERVICE BY ONE OR MORE HEALTH CARE PROVIDERS. AN EXAMPLE OF THIS WOULD INCLUDE TEETH CLEANING SERVICES.

- PAYMENT MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICE CONFIRMEING COVERAGE, BILLING OR COLLECTION ACTIVITES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE SENDING A BILL FOR YOUR VISIT TO YOUR INSURANCE COMPANY FOR PAYMENT.

- HEALTH CARE OPERATIONS INCLUDE THE BUSINESS ASPECTS OF RUNNING OUR PRACTICE, SUCH AS CONDUCTING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, AUDITING FUNCTION, COST MANAGEMENT ANALYSIS, AND CUSTOMER SERVICE. AN EXAMPLE WOULD BE AN INTERNAL QUALITY ASSESSMENT REVIEW.

WE ALSO MAY CREATE AND DISTRIBUTE DE-IDENTIFIED HEALTH INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT YOUR TREATMENT ALTERNATIVE OF OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOU WRITTEN AUTHORIZATION IN WRITING AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXPECT TO THE EXTENT THAT WE HAVE ALREADY TAKEN ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING WRITTEN REQUEST TO THE PRIVACY OFFICER.

- THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO A FAMILY MEMBER, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU. WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.

- THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION FROM US BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS.

- THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.

- THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

- THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OR PROTECTED HEALTH INFORMATION.

- THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US UPON REQUEST.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF OUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

THIS NOTICE IS EFFECTIVE AS OF MARCH 19TH, 2003 AND WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE PRIVACY PRACTICES CURRENTLY IN EFFECT. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. WE WILL POST AND YOU MAY REQUEST A WRITTEN COPY OF A REVISED NOTICE OF PRIVACY PRACTICES FROM THIS OFFICE.

YOU HAVE RECOURSE IF YOU FEEL THAT OUR PRIVACY PROTECTIONS HAVE BEEN VIOLATED. YOU HAVE THE RIGHT TO FILE WRITTEN COMPLAINT WITH OUR OFFICE, OR WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, ABOUT VIOLATIONS OF THE PROVISIONS OF THIS NOTICE OR THE POLICIES AND PROCEDURES OF OUR OFFICE. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT:

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF CIVIL RIGHTS, 200 INDEPENDENCE AVE, S.W., WASHINGTON D.C., 20201. (202)629-0257 TOLL FREE (877)696-6775.