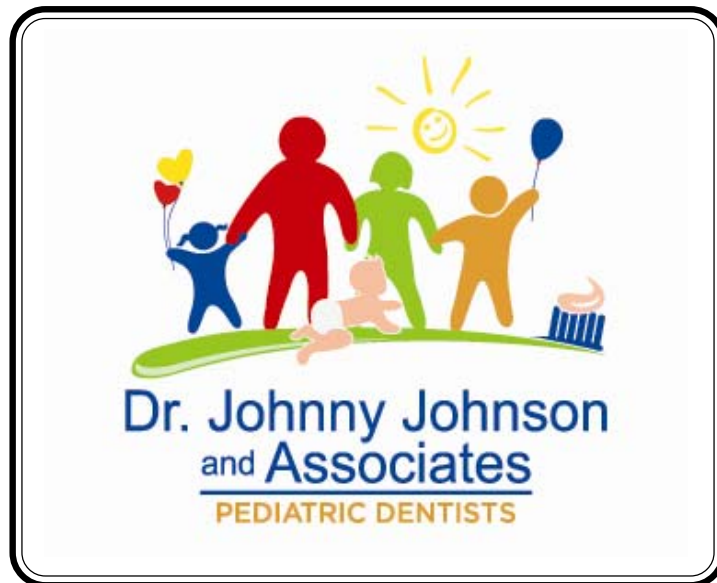


Welcome to the Pediatric Dental Practice of:

**Johnny Johnson, Jr., D.M.D., M.S.
and Associates**

3840 Tampa Road
Palm Harbor, FL 34684
(727) 786-7551



Thank you for choosing our pediatric dental office for your child's dental care. It is our goal to make your child's dental visit a positive experience. We look forward to speaking with you and addressing your dental concerns. Please carefully complete the enclosed medical & dental information so that we may be of better service to you. Thanks!

Please give the date and place of the patient's last physical.

Please note: Please explain all **Yes** answers to questions 2, 4, 6, 8, 9, 10, 11.
Also, describe any other medical problems not yet covered.

DENTAL HISTORY

Yes No

 14. Has the patient ever been to the dentist? If yes, please indicate who and date of last exam.

 15. Will the patient be uncooperative?

 16. Has the patient ever sucked their finger(s), thumb or pacifier? Indicate which and duration.

 17. Does your water have fluoride in it?

 18. Do you give the patient fluoride tablets or prescription vitamins that contain fluoride?

 19. Was the patient bottle fed? If yes, at what age was it completely stopped? _____

 20. Was the patient breast fed? If yes, at what age was it completely stopped? _____

 21. The patient drinks water primarily from:

Public water supply Well water Bottled water: Brand _____

 22. Please indicate if the patient has had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Gum infections | <input type="checkbox"/> Crooked teeth |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Teeth bumped | <input type="checkbox"/> Teeth knocked out |
| <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Color of teeth | <input type="checkbox"/> Other |

23. What is your main concern about the patient's teeth?

24. Each child is special and therefore receives individual attention and care in this office. Is there something in particular that we should know about your child that may guide us in rendering care for them?

Whom may we thank for referring you to our office? _____

Please continue on to the next page

Thank you for choosing our office for your family's Pediatric Dental needs. In order to provide each child with the individual care and attention that they deserve, we ask that they arrive on time for scheduled dental appointments. We respect your need to be treated promptly and for this reason, we receive our patients at their appointed time. Due to the nature of our practice, however, in dealing with children....accidents and emergencies do happen. We ask for your indulgence if we are delayed in seeing you due to seeing another child on an emergency basis.

We make a sincere effort to schedule convenient appointment times for our patients. However, it is necessary to alternate morning and afternoon appointments, particularly during the school term.

Missed Appointments:

Please remember that if you must reschedule your appointment, kindly give us twenty-four hours advance notice. This allows us to offer this appointment time to another patient who may need that particular time. Giving us less than 24 hours notice, or not showing up at your appointed time will be considered a missed appointment. A fee may be assessed for each missed appointment. In addition, repeated missed appointments may result in dismissal from our practice. And believe us, we do not want to see that happen.

Your comments regarding our office and staff are welcome and greatly appreciated!!! Please feel free to share your comments with us:

Financial Payment Options:

We request of everyone that payment be made at the time of service.

If the patient is covered by dental insurance, we will be happy to offer you the convenience of filing your insurance for you. As with any health care insurance, your dental benefits are based on what the insurance company will pay for your child, according to the company plan that you have, not the insurance company itself, as the same company will have multiple plans offering different levels of benefits. Your child's benefits are between you, the premium payer, and the insurance company. Any difference between what the insurance company pays and our fees will be the responsibility of the insured.

Outstanding balances will be assessed at a rate of 1.5% monthly percentage (18.00% APR) to accounts over 30 days past due.

If the patient is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services can be rendered.

Authorization is hereby granted for the dental consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent. I will be responsible for any fees incurred on this patient for dental treatment.

Date _____

Signature _____

Relationship to patient _____

Legal guardian (*if different*) _____

******* IMPORTANT*******
**** NOTE REGARDING INSURANCE****
DR. JOHNNY JOHNSON & ASSOCIATES'
OFFICE GLADLY HELPS WITH
INSURANCE ESTIMATES AND FORMS,
BUT WE ARE NOT A
'PARTICIPATING PROVIDER'
FOR ANY INSURER.
BALANCES NOT PAID BY YOUR
INSURER ARE YOUR RESPONSIBILITY.
INITIALS _____

Drs. Alex and Johnny Johnson and Associates

3840 Tampa Road, Palm Harbor, FL

727-786-7550, 727-786-7551

**CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE
AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION**

I, _____, hereby authorize Drs. Alex and Johnny Johnson and Associates (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning

_____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

___ HIV records (including HIV test results) and sexually transmissible diseases

___ Alcohol and substance abuse diagnosis and treatment records

___ Psychotherapy records

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain) to _____ at _____ . I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.
2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies will be ready on _____ .
3. I acknowledge I will be charged copying costs in the amount of _____ .

By Patient: _____
(Print name and sign)

Date: _____

Patient's: Date of Birth: _____

Social Security #: _____

Or

By Parent: _____
(Print name and sign)

Date: _____

Or

By Patient's Representative: _____
(Print name, sign, **and describe authority**)

Date: _____

“Our office has always placed the utmost importance on the privacy of our patient’s health information.”



Privacy Practices

Under a newly implemented Federal Law, we are required to have you read and sign an Acknowledgement of our office’s Notice of Privacy Practices (NOPP). The Notice of Privacy Practices is a document which describes how our office handles the privacy of your health information.

Our Approach Remains the Same

Our office has always placed the utmost importance on the privacy of our patient’s health information. We have always had the policy that your health information will not be shared with anyone without your permission. This law is intended to protect all patients from improper disclosure of protected health information, and that is good. It won’t change how we handle your health information. That is how we have always practiced.

What You Need To Do

You will be asked to sign two forms that will be kept in your file or your children’s file so that we may comply with this new law (only one form needs to be signed for all children in your family...just insert all children’s names on one form and we’ll do the rest). These forms will allow us to continue to provide your family with “business as usual” service. We will provide you with a copy of the NOPP form for your records.

Thank You for Your Time

We appreciate your time in completing this form. As always, please feel free to ask us for assistance or to answer any questions you might have.

Dr. Johnny Johnson
& Associates
3840 Tampa Road
Palm Harbor, FL 34684

Analysis Form to Determine Fluoride Intake

A Note from Drs. Johnny & Maggie:

This information is to be used solely by our office to determine that our patients are receiving the proper amount of fluoride to benefit their teeth against decay. As with all of our patient's confidential information, it will be kept in the patient's chart and will not be shared with any outside sources in accordance with HIPAA regulations.

Family Name: _____ **Date:** _____

Filters: Reverse Osmosis /"RO" Whole House Carbon (*not per tap, ie., Brita*)
(**The above filtration systems successfully remove most fluoride from water, so testing will be recommended if these are used in the home*)

Water: Is your home in a fluoridated area (see map)? Yes No Unsure

- Home **Drinking** Water: Tap, RO, Bottled (Brand = _____ with / without fluoride?)
- Home **Cooking** Water: Tap, RO, Bottled (Brand = _____ with / without fluoride?)
- **Mix Juices** with: Tap, RO, Bottled (Brand = _____ with / without fluoride?)

Child: _____ **Child's d/o/b** _____

Taking Fluoride Supplements or Prescription Vitamins with Fluoride? Yes No

If yes, Dosage: ___ mg Tab ___ ml Liquid Brand _____

Check all that apply: Does your child spend time at a school, daycare, or caretakers' home ?

List: _____

Days/week _____ Hours/day _____

Is the •school, •daycare, or •caretakers' home in a fluoridated area (see map)?

School: Yes No Unsure

Daycare: Yes No Unsure

Caretaker's Home: Yes No Unsure

Do you send water to •school, •daycare, or •caretakers' home from home?

Yes No

If "Yes", Tap or Bottled?

(Bottled Brand = _____ with / without fluoride?)

Signature / Person completing this form

Date

(for additional children please complete a separate form)

For Office Use:

Recommendations:

Home Water If it contains no Fluoride, switch to fluoridated bottled water. Yes No

Currently Available: **Checking**

Filtration: Yes No (If Yes, call us back with results)

RO Whole House Carbon

Supplements: Discontinue: Yes No

Modify: Yes No

Dosage: _____

Comments: