Welcome!

J. Bruce Johnson, D.D.S.

Creating Radiant Smiles

Our goal is to make every child's visit pleasant and educational. Please help us provide your child with excellent care by communicating any questions, concerns or other information that may help us make your child comfortable.

Child's Information

Today's Date:___/___/___ Reason for Visit:_____

Child's Name:_____ Birthdate:___/___/___ Age:____ ❒Male ❒Female
First MI Last

Child's Home Address:_____ Home Phone:_____
Street (Apt. #) City State Zip

School:_____ Grade:___ Other family members seen by Dr. Johnson:_____

Who is accompanying the child today?_____ Do you have legal custody of this child? Y N
Name Relationship

Child's SS#:_____-_____-_____ Whom may we thank for referring you?_____

Child's past / present dentist:_____ Emergency Contact:_____ Phone:_____
(Please Circle One) (Other than Parents)

Parent's Information

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

❒Mother ❒Step-Mother ❒Guardian
Name:_____ Birthdate:_____

Address (if different than child's):_____

_____

SS#:_____ DL#:_____

Work Ph:_____ Cell:_____

Email: _____

Employer/Occupation_____

❒Financially Responsible for account

❒Child is covered by this individual's insurance plan

❒Father ❒Step-Father ❒Guardian
Name:_____ Birthdate:_____

Address (if different than child's):_____

_____

SS#:_____ DL#:_____

Work Ph:_____ Cell:_____

Email: _____

Employer/Occupation_____

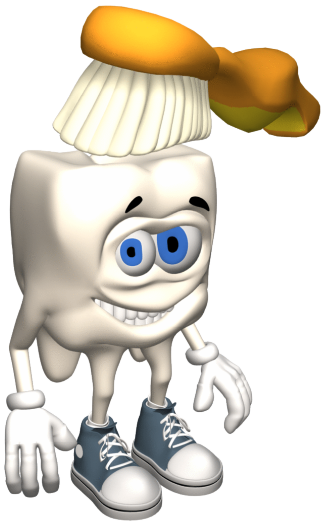
❒Financially Responsible for account

❒Child is covered by this individual's insurance plan

Dental History

The child's current dental health is: ❒ Good ❒ Fair ❒ Poor

Y N Is the child currently in pain?
Y N Is this the child's first visit to the dentist?
Y N Has the child ever had any orthodontic treatment?
Y N Has the child ever had any pain/tenderness in the jaw joints?
Y N Has the child ever taken Phen-Fen (also known as Redux or Pondimin)?
Y N Does the child have a strong gag reflex?
Y N Does the child brush his / her teeth daily?
Y N Has the child had any permanent teeth extracted?
Y N Does the child require antibiotics before dental work?
Y N Has the child ever had a serious problem associated any previous dental treatment or dental anesthetics?



Tell Us a Little About Your Child

Do you have a nickname you would like us to use instead of your first name?_____

Do you have any pets? What kind & what are their names?_____

Do you play any sports? Which one(s)?_____

Do you play any musical instruments? Which one(s)?_____

Do you have any favorite hobbies?_____

What are your favorite things to do after school or on the weekends?_____

_____

What is your favorite TV show?_____

What is your favorite book?_____

Medical History

Child's Physician: _____ Phone # or City: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? Y N The child's current physical health is: ❒ Good ❒ Fair ❒ Poor

Please list any **medications** the child is currently taking:_____

Please list all substances the child is **allergic** to:_____

Are the child's immunizations current? Y N Is there anything that you would like to discuss with the doctor in private? Y N

Has the child ever been hospitalized or had any major operations? _____

Has the child ever had a serious injury to the face, mouth, teeth, chin, head or neck?_____

Does your child have any special needs we should be aware of? _____

Has the child ever experienced any of the following medical conditions? Please circle yes (Y) or no (N) for each of the following:

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Adenoids / Tonsils Removed
Y N AIDS / HIV
Y N Anemia
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma
Y N Autism
Y N Blood Transfusion
Y N Cancer / Leukemia
Y N Chicken Pox
Y N Cleft Lip / Palate
Y N Congenital Heart Defect
Y N Diabetes
Y N Digestive Disorder
Y N Down Syndrome
Y N Eating Disorder
Y N Epilepsy / Seizures
Y N Excessive Thirst
Y N Fainting
Y N Frequent Ear Infections
Y N Frequent Headaches
Y N Frequent Illness
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis A B C
Y N Herpes / Fever Blisters
Y N High / Low Blood Pressure
Y N Immune System Disorder
Y N Intestinal Disorders
Y N Kidney Problems
Y N Latex Allergy
Y N Learning Disabilities
Y N Mitral Valve Prolapse
Y N Mononucleosis / Epstein-Barr
Y N Muscular Dystrophy
Y N Neurological Problems
Y N Prosthetics _____
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Scoliosis
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Special Diet
Y N Spina Bifida
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Visual Impairment

Please circle yes (Y) or no (N) for each of the following as they pertain to the child

Y N Trouble In Utero (Please Explain): _____

Y N Birthing Trauma (Please Explain): _____

Y N Speech Problems
Y N Mouth Breather
Y N Chewing on Objects
Y N Tongue Thrust
Y N Thumb / Finger Sucking
Y N Used Pacifier
Y N Nail Biting
Y N Tongue / Cheek Biting
Y N Cesarean Delivery
Y N Nursing Bottle Habits
Y N Lip Sucking / Biting
Y N Clenching / Grinding teeth
Y N Premature Delivery @ _____wks
Y N Breast Fed-How long? _____
Y N Forceps Used in Delivery

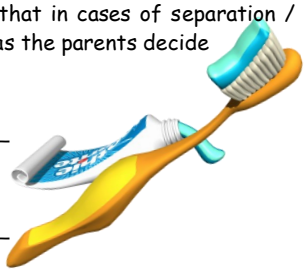
Please list or describe any medical / dental issues not otherwise indicated through this form:_____

_____

"I affirm that the information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize Dr. Johnson and his staff to examine, clean, and provide my child with comprehensive dental treatment including fillings, crowns, extractions, and diagnostic procedures, if required. I have reviewed to my satisfaction the *Dental Materials Fact Sheet, Dental Oxygen/Ozone Therapy Information,* and the *Notice of Privacy Practices* and I authorize the dental staff to perform the necessary dental services my child may need including dental x-rays to diagnose and/or treat my child's dental condition. I understand and agree that documentation may include video or audio recordings.

"I authorize the release of information to J. Bruce Johnson, D.D.S., from any past or current health care provider. I authorize the release of my child's medical / dental records to other health care providers whose care he/she is or may come under. I understand that any diagnostic and treatment records remain the property of the doctor but are available for referral. I consent to the use of my child's diagnostic and treatment records without his/her identity being revealed.

"I understand that I am responsible for any charges incurred on this child for services provided here, and that in cases of separation / divorce, each parent is solely responsible for any and all charges incurred for the benefit of his or her child. Should we as the parents decide to split payments of that account, we understand we may do so among ourselves."



_____

Mother (as listed on front) Print Name Signature Date

_____

Father (as listed on front) Print Name Signature Date

FOR OFFICE USE ONLY

[REV0621]

Reviewed: Date:_____ Staff Initials:_____ Doctor's Signa-

J. BRUCE JOHNSON, D.D.S.
Creating Radiant Smiles

FINANCIAL AGREEMENT

Our practice is committed to providing optimal treatment for our patients based on a diagnosis of what is in the best interest of their dental and overall health & well-being. We do not negotiate fees or adjust treatment due to insurance restrictions.

1. PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.
2. WE ACCEPT *CASH*, *CHECK*, *VISA / MASTERCARD*, *DISCOVER, AMERICAN EXPRESS, & CARE CREDIT* .
3. APPOINTMENTS CANCELLED LESS THAN 48 BUSINESS HOURS ARE SUBJECT TO A BROKEN APPOINTMENT FEE.
4. WE WILL PREPARE & SUBMIT CLAIMS FOR APPLICABLE PPO / DPO DENTAL INSURANCE.
5. NO SERVICES CAN BE SUBMITTED TO HMO / DMO INSURANCE PLANS, MEDICARE, DENTI-CAL, OR OTHER SIMILAR PROGRAMS.

_____ INITIAL HERE

Please be prepared to make payment at the time of your appointment. Any alternate arrangements must be made with the front desk prior to your appointment. An account is deemed delinquent if payment is not received in accordance with this policy or a separate mutually agreed upon arrangement. Delinquent accounts are subject to a finance charge of 18% APR (regardless of insurance) and no further treatment can be scheduled until the balance is resolved. You agree to pay all legal expenses necessary for the collection of any debt.

_____ INITIAL HERE

Checks are accepted with proper identification. There is a returned check fee of $35 and alternate means of payment may be required for future charges. A Broken Appointment Fee of $50 is applicable to any appointments not cancelled or rescheduled with a staff member at least 48 business hours prior to the appointment time.

_____ INITIAL HERE

If you have a PPO / DPO Dental Insurance Plan, we will prepare and submit claims provided you complete the Insurance Agreement with valid information with the understanding that you are responsible for payment of services rendered. Your estimated patient portion is due at each visit. Once your insurance has made payment to our office (Assignment to Doctor), or **31 days** from the date of submission, any remaining balance will be charged to your credit card on file.

_____ INITIAL HERE

If you do not maintain a credit card on file, any remaining balance must be paid within 30 days of the insurance payment, or 31 days from the date of submission, or you may forfeit your Assignment to Doctor status; you will be required to make payment in full when services are rendered and be reimbursed by your insurance company.

_____ INITIAL HERE

HMOs, Medicare, and similar programs will not reimburse and cannot be billed for services rendered in this office. If you are covered by Medicare please check the box on the back of this form, read thoroughly, sign and date.

_____ INITIAL HERE

Flexible Spending/Savings Accounts vary greatly. It is your responsibility to know the requirements of your plan, request documentation in a timely manner and meet your deadlines. We can only run cards in your presence and reversals of charges cannot be handled by our office.

_____ INITIAL HERE

By having services rendered you agree that you are ultimately responsible for all charges incurred. This agreement applies to any patient for which you are the account guarantor and supersedes all prior agreements signed. In the event that financial responsibility changes, you understand that you remain financially responsible until a new agreement is signed and accepted by our office.

Patient Name (If other than Guarantor) Guarantor Name Social Security # Driver's License #

Signature of Account Guarantor _____ Date_____

CREDIT CARD ON FILE: "I authorize Dr. J. Bruce Johnson to charge this credit card in accordance with the above agreement. "

PRINT CARDHOLDER NAME CARDHOLDER SIGNATURE

_____ _____-_____-_____-_____ ___/___ _____ _____

TYPE OF CARD CARD # EXP. DATE CVV CODE BILLING ZIP CODE

INSURANCE AGREEMENT

Rev 1017

Please present your insurance card(s). All fields are required in order for us to assist you with your insurance.

Primary Dental Insurance Company

INS. CO. NAME: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ SS #: _____

SUBSCRIBER ID #: _____ PATIENT'S SS #: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

INSURED'S EMPLOYER: _____

(IF INSURANCE IS THROUGH EMPLOYER)

EFFECTIVE FROM: ___/___/___ EFFECTIVE UNTIL: ___/___/___

Secondary Dental Insurance Company

INS. CO. NAME: _____

PHONE #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ SS #: _____

SUBSCRIBER ID #: _____ PATIENT'S SS #: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

INSURED'S EMPLOYER: _____

(IF INSURANCE IS THROUGH EMPLOYER)

EFFECTIVE FROM: ___/___/___ EFFECTIVE UNTIL: ___/___/___

❑**"I am covered by Medicare"** I understand that services provided by Dr. Johnson will not be covered by Medicare (or other similar programs) and that by seeking treatment from Dr. Johnson I am privately contracting for his services. I agree not to make submissions to Medicare for services rendered by Dr. Johnson and understand that his office will not make submissions to Medicare (or other similar programs) for services rendered. **I am opting-out of Medicare benefits for services which may have otherwise been covered by Medicare.**

MEDICARE OPT-OUT: _____

SIGNATURE DATE

_____ INITIAL HERE You are entering into a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for treatment. **The doctor is not a party to your contract with your insurance company. By assisting with or submitting insurance claims and / or accepting assignment of your insurance benefits we are in no way releasing you of your financial obligations and responsibilities.**

_____ INITIAL HERE Although we may receive information about your insurance coverage which allows us to provide estimated insurance payments, it is your responsibility to know the provisions of your plan. Further, we are not privy to benefits used elsewhere which may reduce or negate payments for services provided in this office. You remain financially responsible for the cost of treatment provided.

_____ INITIAL HERE As a courtesy, we will prepare and submit claims on your behalf to applicable PPO / DPO primary and secondary dental insurances. You are responsible for 1) providing complete, accurate insurance information and notifying our office of any changes in coverage 2) tracking or ensuring payment of claims and resolution of delays or disputes by your insurance company. In the event your insurance company states they have not received a claim, we will gladly make **one** duplicate submission. If the problem persists, we will provide you a copy of your claim to resubmit.

_____ INITIAL HERE The estimated patient portion, including any deductible, on covered services and 100% of non-covered services is due at the time of each visit. You are responsible for resolving disputes which may delay the processing and payment of claims. If a claim is pending after **31** days from submission, you may be required to make payment. Any balance remaining after a claim has been paid by your insurance company will be charged to your credit card on file; if you do not maintain a credit card on file, payment must be made no later than 30 days from the date the claim is processed or you may forfeit your *Assignment to Doctor* status.

_____ INITIAL HERE If you fail to fulfill the terms of the financial agreement (making timely payment of any remaining balance after claims processing), payment is **due in full when services are rendered** and your insurance company will be instructed to send any reimbursement directly to you.

AUTHORIZATION FOR SUBMISSION OF CLAIMS / ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize J. Bruce Johnson, D.D.S. to submit claims for services performed to the healthcare service plans or insurance companies under which I (or my dependents) am covered. These claims are to be submitted on my behalf and the benefits which would otherwise be payable to me may be assigned to J. Bruce Johnson, D.D.S.. I understand that my dental insurance carrier may pay less than the actual bill for services; I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby give permission to Dr. J. Bruce Johnson to release all information necessary to secure the payment of benefits by any person or corporation (1) which is or may be liable or under contract to Dr. Johnson for reimbursement for services rendered, and (2) any health care provider for continued patient care. This includes the legal guardian of patients over the age of 18 who are covered under the guardian's health/automobile insurance. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____ _____

PATIENT OR GUARANTOR: NAME SIGNATURE DATE

J. Bruce Johnson, D.D.S. (818) 248-7976 3909 Ocean View Blvd. - Montrose, CA 91020

Important Office Policies

Patient-Provider E-mail Agreement: Email offers an easy way to communicate and has advantages over office visits or telephone calls, but there are important differences. Email is not the same as calling our office. There is no person at the other end of the call- just a computer. You can't tell for certain when your message will be read. Nonetheless, we believe that the ease of communication email affords is a benefit to better patient care. Below are our guidelines for contacting us using email.

- Email is never an appropriate option for urgent or emergency problems! Please use the telephone or go to your nearest hospital's emergency room for emergencies.
- Email is not confidential and should not be used to communicate sensitive medical or financial information including credit card numbers. Remember: email services do not promise complete privacy; they are not HIPAA-compliant and are not encrypted even though they are password protected.
- Emails may become a part of your medical record.
- Email is **not** a substitute for seeing the doctor. If you think that you might need to be seen, please call and book an appointment.
- Email is great for asking those little questions that don't require a lot of discussion and are not time-sensitive. If the staff feels that your email requires addressing more in depth, they will let you know that an appointment with the doctor is more appropriate than an email response.
- If you have not had a response to your email in a timely manner, please call the office- we receive a high volume of emails and occasionally patient emails are automatically filtered out of our inbox. We're ALWAYS happy to hear from you.

Children and Child-Care in the Office: We appreciate your understanding that our reception area and office serve patients of all ages and we do not provide childcare- if you must bring small children with you, please also bring a care-taker. While we have a child area to help children pass time for sibling or parent appointments, children should never be left unattended and we ask that you respect the privacy and experience of other patients by supervising your children's activities and noise levels during your time in our office. If we can provide any comforts to help with this please let us know. We will always do our best to help little ones feel at ease in our office.

Photographs: It is important that you understand that while seeking healthcare services from Dr. Johnson, we have a responsibility to maintain proper records and documentation of your (or your child's) care. These records include photographic documentation. Initial visits may include photographs with subsequent photo documentation taken during the course of your care. By electing to receive care at this office you are consenting to the doctor and staff acquiring appropriate clinical documentation. Healthcare professionals are held to standards of care which require the doctor and staff to ensure recommended and appropriate diagnostic and preventative procedures are prescribed and received. If you choose to refuse these services, you may transfer your care to another provider, to which your records will be provided upon receipt of a signed release form.

OUR POLICY REGARDING X-RAYS

We cannot provide the care you deserve without the proper diagnostic information, which includes x-rays; we will take the minimum amount of x-rays possible to properly evaluate your oral health. For new patients, we require a complete and current set of x-rays. If you have had a full set of x-rays within the past 3-5 years, you will need to request to have those x-rays transferred to our office. If the x-rays are less than 3 months old, we will not require any updated x-rays. If they are older than 3 months old, a set of check-up x-rays will be taken at the time of your first visit. We start x-rays for children around the age of 6 years old. For children who do not yet have all of their permanent teeth erupted, check-up x-rays will be taken in lieu of a complete adult set. Diagnostically appropriate dental radiographs help the dental practitioner evaluate and definitively diagnose many oral diseases and conditions. Their necessity includes:

- Providing valuable information about things we can't see under the gums, under fillings, and between teeth
- Identifying problems that are asymptomatic or undetected clinically
- Finding decay and seeing the status of developing teeth
- Evaluating root structure, checking the health of the bone, and diagnosing periodontal disease

Established patients who are under general dental care from Dr. Johnson (some patients come here for specialized care while maintaining their general dental needs with their existing dentist) will have check-up x-rays annually, with a full set every 3-5 years depending on the state of their oral health. If you maintain your general dental care with another dentist, we may request copies of the x-rays taken at that office.
If you elect to refuse x-rays, we may request you transfer your care to another dental office. To proceed properly in the complete care of your dental system requires diagnostic information, some of which is only achievable through x-rays. Finances unfortunately often play a part in our healthcare choices. If your concerns over x-rays are related to finances, please let one of our front desk team members know so that we can help you with options.

If you have concerns related to radiation exposure, please be aware that the dosage is extremely small for dental radiographs, further reduced with the use of digital imaging. Please take some time in advance of your appointment to consult the National Council on Radiation Protection, the American Dental Association, and the California Dental Association, for information.

If you have concerns about having x-rays taken at your visit, or routine x-rays during your time as our established patient, please discuss them with the doctor.

Patient Name:_____ Guardian Name: _____

Patient or Guardian Signature:_____Date: _____