JOHN S. JOHNSON DDS

5102 Salem Ave. Lubbock, TX 79414 (806) 687-8080 Fax (806) 771-6862

Patient Information

Child's Name_____ M ( ) F ( )
Age_____ Date of Birth_____School/Daycare_____
Home Address_____ City _____ State___ ZIP_____
Home Phone _____Mobile Phone _____Message _____
Work Phone _____ E-mail _____
Emergency Contact Name_____ Phone # _____

Insurance Information

Dental Insurance Plan? YES [ ] NO [ ] Insurance Company_____ Phone # _____
Medicaid? YES [ ] NO [ ] CSHCN? YES [ ] NO [ ]
Please provide your card for the receptionist. Please bring the current card for each appointment.

Medical and Dental History

Child's Physician/Pediatrician _____ Phone # _____
Is your child presently under medical care? YES [ ] NO [ ] If yes, explain _____
Is your child currently taking medication? YES [ ] NO [ ] If yes, List_____
Any known allergies or reactions (medications, food, etc.)? YES [ ] NO [ ]
If yes, explain _____
Has your child ever had any of the following medical problems?

Heart Disease	YES NO	Kidney Problems	YES NO	Tuberculosis	YES NO
Heart Murmur	YES NO	HIV/AIDS	YES NO	Bone Problems	YES NO
Heart Defect	YES NO	Blood Disorder	YES NO	Asthma	YES NO
Rheumatic Fever	YES NO	Diabetes	YES NO	Hearing Loss	YES NO
Epilepsy/Fainting/Seizures	YES NO	Hepatitis	YES NO	Vision Loss	YES NO
Liver Problems	YES NO	Cancer/Leukemia	YES NO	Surgery	YES NO
Down Syndrome	YES NO	Cerebral Palsy	YES NO	Birth Defects	YES NO

Please explain any other relevant health problems: _____
First Dental Visit? YES [ ] NO [ ] If no, who was the previous dentist? _____
Previous dental treatment (filings, crown, extractions?) YES [ ] NO [ ] If Yes, explain_____
Previous sedation or general anesthesia for dental treatment? YES [ ] NO [ ] If yes, _____
Has your child experienced any unfavorable reaction from previous dental care? YES [ ] No [ ]
If yes, Explain_____
Has your child ever fallen or otherwise injured his/her teeth? YES [ ] NO [ ]
If yes, When? _____How? _____ Effects? _____
Any bad mouth habits (finger, thumb, pacifier, etc.) YES [ ] NO [ ] Explain_____
Does your child have siblings? YES [ ] NO [ ] Also patients with us? YES [ ] NO [ ]
If yes, please list_____

Parent/Guardian/Other Adult Information

Name_____SSN_____
Employer _____ Phone_____
Martial Status S [ ] M [ ] D [ ] Relationship to child: Father [ ] Mother [ ] Other_____
Name_____SSN_____
Employer _____ Phone_____
Martial Status S [ ] M [ ] D [ ] Relationship to child: Father [ ] Mother [ ] Other_____
Person responsible for account: _____
Billing address_____

Payment is due the day services are rendered.

I hereby authorize John S. Johnson DDS to furnish information to my insurance carrier concerning dental treatment. I hereby assign all payments for dental services rendered to John S. Johnson DDS. I understand I am responsible for amounts not covered.

Signature_____ Date_____

Signature_____ Updated on _____

Signature_____ Updated on _____