



Donald J. Johnson, DDS

Today's Date: _____
Referred By: _____

FAMILY INFORMATION

Name: _____
Patient or Person Responsible for Account
Address: _____
City: _____ **St** _____ **Zip** _____
Birth Date: _____
SSN: _____ - _____ - _____
Home Phone: (____) _____ - _____
Work Phone: (____) _____ - _____ **Ext:** _____
Cell Phone: (____) _____ - _____
Occupation: _____
Employer: _____

INSURANCE INFORMATION:

Primary Coverage

Insured's Name: _____
Primary Subscriber
SSN: _____ - _____ - _____ **or ID #** _____
DOB: _____
Address: _____
City _____ **St** _____ **Zip** _____
Home Phone: (____) _____ - _____
Employer: _____
Insurance Company: _____
Address: _____
City _____ **St** _____ **Zip** _____
Group No.: _____
Toll Free Phone No.: (____) _____ - _____

Name of Spouse: _____
Birth Date: _____
SSN: _____ - _____ - _____
Cell Phone: (____) _____ - _____
Work Phone: (____) _____ - _____ **Ext:** _____
Occupation: _____
Employer: _____

Secondary Coverage

Insured's Name: _____
Secondary Subscriber
SSN: _____ - _____ - _____ **ID #** _____
DOB: _____
Address: _____
City _____ **St** _____ **Zip** _____
Hm Phone: (____) _____ - _____
Employer: _____
Insurance Company: _____
Address: _____
City: _____ **St** _____ **Zip** _____
Group No.: _____
Toll Free Phone No.: (____) _____ - _____

Children: (List those who are currently, or may become minor patients of Dr. Johnson)

Name: _____ **DOB:** _____
Name: _____ **DOB:** _____
Name: _____ **DOB:** _____
Name: _____ **DOB:** _____
Name: _____ **DOB:** _____
Name: _____ **DOB:** _____

-This section office use only-

Date policy effective _____
Frequency Limitations _____

Name of relative not living with you:

Relationship: _____
Address: _____
City: _____ **St** _____ **Zip** _____
Phone: (____) _____ - _____

Yearly Maximum _____
Deductible _____
Preventive _____
Restorative _____
Major _____



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Donald J. Johnson, DDS

Assignment and Release for patients with Insurance

I certify that I, and/or my dependant(s), have insurance coverage and assign directly to Dr. Donald J. Johnson, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature: _____ Date: _____
Insured Patients

All Patients must sign below

In consideration of the service rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policy. I accept full financial responsibility for all charges and services.

Signature: _____ Date: _____
All Patients

If patient is a minor, Parent or Guardian must sign

- * Visa or MasterCard are accepted
- * Emergencies – Full pay at time of treatment cash/check/credit card
- * No Post Dated Checks
- * Senior Citizens 60 and over 10% discount