

PATIENT INFORMATION

Dental Office of Whitney R. Johnson, D.D.S.

Patient's Full Name:	_____	Mrs. Ms Miss Mr. Dr Prof
Preferred Name:	_____	Birth Date: _____
Social Security Number:	_____	Patient's Email _____
Patient's Cell Phone:	_____	Patient's Work Phone: _____ Ext: _____
Patient's Home Phone	_____	
Patient's Street Address:	_____	Address 2: _____
City	_____	State _____ Zip _____
Student Status if Dependant Over 19 (for insurance)	___ Nonstudent ___ Fulltime ___ Parttime	
College Name	_____	

RESPONSIBLE PARTY'S INFORMATION

Responsible Party's Name	_____	Relationship	_____
Responsible Party's Address	_____		
City	_____	State	_____ Zip _____
Responsible Party's Home Phone	_____	Responsible Party's Work Phone	_____
Responsible Party's Date of Birth	_____	Responsible Party's Social Security Number	_____

DENTAL INSURANCE INFORMATION

Name Of Dental Insurance Company	_____		
Address Of Dental Insurance Company	_____		
Name Of Insured	_____	Social Security Number of Insured	_____
Insured's Group Number	_____	Name of Employer	_____
Name of Secondary Dental Insurance	_____		
Address of Secondary Dental Insurance Company	_____		
Name of Secondary Insured	_____	Soc. Sec. Number Of Second Insured	_____
Secondary Insured's Group Number	_____	Name Of Secondary Employer	_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made prior to dental treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____ Date _____
___ Adult Patient ___ Father(or Husband) ___ Mother(or wife) ___ Guardian

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