PATIENT REGISTRATION & INSURANCE

Date _____

Patient's Name _____ Preferred name _____

Address _____ City, State, Zip Code _____

Home Phone _____ Social Security # _____

Date of Birth _____ Spouse's Name _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Sex: Female ☐ Male ☐

Employed by _____ Occupation _____

Employer's Address _____

Work Phone _____ Ext _____ Cell Phone/Pager _____

Preferred method of contact? Home ☐ Cell ☐ Work ☐ E-Mail _____ or Text ☐

Physician Name & Address _____ Last Visit _____

Whom should we contact in case of emergency? _____

Relationship _____ Phone _____

Whom may we thank for referring you? _____

Hobbies or Interests? _____

COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE

Insured's Name _____ Insured's Birth Date _____

Insured's Social Security # _____ Insured's Employer _____

Insurance Group # _____ Insurance Co. _____

Address _____ Phone # _____

Do You Have Any Other Dental Insurance? Yes ☐ No ☐

READ CAREFULLY AND UNDERSTAND WHAT YOUR SIGNATURE MEANS. Your signature below serves many purposes. It indicates you have reviewed your medical history and personal registration information and updated and corrected it as appropriate (including your phone numbers) to ensure that they are correct. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to Ernest N. Johnson D.D.S. and the release of information to all insurance carriers. I authorize Dr. Johnson to utilize any photos taken in conjunction with treatment for diagnostic and educational purposes. And finally, the undersigned accepts all responsibility for payment of this account and understands that a 1.5% (18% APR) monthly service charge is assessed on ALL balances over 30 days.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____