Who may we thank for referring you to our office? ______________________________

Patient Information

Patients Name______________________ Preferred Name______________ Male/Female

Birth Date ____________ Age_____ SS# ________________ Marital Status S M D O

Address __________________________ City/State _________ , ________ Zip ________

Home Phone _____________ Employer __________________ Work Phone__________

Cell or other phone ____________ Email Address____________ DL#________________

Person Responsible for Account ______________________ Relationship _____________

Birth Date ____________ Age_____ SS# ________________ DL#________________

Address __________________________ City/State _________ , ________ Zip ________

Phone _____________ Employer ______________________ Work phone ___________

In Case of an Emergency: (that does not live with you)

Name of Nearest Relative or Friend__________________________ Phone____________

Address _______________________ City / State _______ , ______ Zip _____________

Primary Dental Insurance Information

Insured Name _____________________ ID# ________________ Birth Date _________

Insurance Company__________________ Group or Policy Number____________________

Ins. Address ______________________ City / State ________ , _________ Zip ________

Insurance Phone ___________________ Insurance Fax (if available)__________________

Employer _______________________ Employer Phone Number____________________

Secondary Dental Insurance (complete only if covered by two insurance companies)

Insured Name _____________________ ID# ________________ Birth Date _________

Insurance Company__________________ Group or Policy Number____________________

Ins. Address ______________________ City / State ________ , _________ Zip ________

Insurance Phone ___________________ Insurance Fax (if available)__________________

Employer _______________________ Employer Phone Number____________________

PAYMENT AGREEMENT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with the extension of credit, please be advised of the following policy which applies to this office. The responsible party agrees to:

Pay the doctor at the time services are rendered. I understand that Dr. Johansen will submit an insurance claim on my behalf but all charges incurred are ultimately my responsibility. A finance charge of 1.5% will be added to all accounts over 60 days old. If a collection agency is required I agree to pay collection fees, up to 40%, which will be added to my outstanding balance.

Responsible Person Signature ________________________________ **Date** _________________