ACCOUNT INFORMATION

Patient Name____ Date of Birth________________

Mailing Address ______________________________________ Zip_________ SS# ________________

Home Phone ______________ Work Phone ___________________ Cell Phone ___________________

E-Mail Address__________________________ Occupation ____________________________________

Employer _______________________ Employer Address _____________________________________

Name of Spouse/Parent __________________________ Spouse/Parent Employer ___________________

INSURANCE INFORMATION

Primary Insurance Company_____________________________________ Group # _________________

Insurance Company Address __________________Phone #__________________ Employer _________

Subscriber Name __________________________ Date of Birth ____________ SS# __________________

Were you referred by one of our patients? ____Yes ____ No
If yes, whom may we thank? ____
If no, where did you hear about us? ____

OFFICE FINANCIAL POLICY

As a part of our overall service, we will prepare and submit your insurance for you as a professional courtesy. However we must emphasize that we cannot guarantee that any insurance claims will be paid. Payment of fee for services will be reviewed with you prior to each appointment. Full responsibility for payment of services rendered belongs to the patient or the parent/guardian. We request all account balances be paid in full unless other arrangements have been made.

- Dr Johnson offers a 5% prepayment savings for any patient paying in advance for treatment.
- A 1.5% finance charge per month will be applied to any accounts over 30 days.

We request 48-hour notification for any changes in your reserved appointment time.

CONSENT FOR TREATMENT

Here at our practice; our goal is to achieve the best dentistry has to offer with comfort and care. Unforeseen conditions may arise during a procedure including but not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed, prolonged feeling of numbness, which in rare circumstances, may be permanent. Should you experience any of these or other conditions during or following treatment, please contact us a soon as possible.

Acknowledge and Consent

I have read the above financial policy statement and acknowledge responsibility for this account.
I authorize release of any information relating to dental claims to my insurance company.
I have read and consent for Kirk A. Johnson DDS PC and his team members at Excellence in Dentistry to perform my dentistry and my family's dentistry under their advisement, supervision and care.

Signature____Date ____________________