

## **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 TO RECEIVE E-MAIL COMMUNICATION**

I give consent to use e-mail as a source of communication with Excellence in Dentistry.

## **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 as 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 \_\_\_\_\_