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 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 _____

Excellence In Dentistry

Dr. Kirk Johnson
Dr. Dale Burke

PHOTOGRAPHIC RELEASE AND CONSENT

I, _____, hereby grant to ***Excellence In Dentistry*** and its representatives the irrevocable and unrestricted right to reproduce and display photographs of me in print, on the ***Excellence In Dentistry*** website, or any other lawful purpose for advertising. I release ***Excellence In Dentistry*** and its employees and legal representatives from any and all claims, actions and liability to its use of said photographs.

The following exclusions may apply: _____

_____

Signature:_____ Date: _____

MINORS ONLY:

If signature above is by a person under the age of 18, parent or guardian should sign below:

I, _____, the parent or guardian, hereby consent to the foregoing.

Signature: _____

Date: _____