The Office of Dr. Peter F. Johnson

Patient Registration Form:

Today's Date_____

Name_____ Home Phone_____
Last First

Address_____ Business Phone_____
Number Street

City/St_____ Zip Code_____ Cell Phone_____

Occupation_____ Email Address_____

Date of Birth_____ Sex: M F Social Security Number_____

Name of Spouse_____

Closest Relative/ Emergency Contact_____ Phone_____

If you are completing this form for another person, what is your relationship to this person?

Who may we thank for referring you to our office?

Release for Treatment:

I authorize DR. JOHNSON and any other agents or employees as selected by them to treat me. This treatment may require the administration of local anesthetics (EXCEPT for _____, which I am allergic to). Although these anesthetics are used for my benefit, they may occasionally cause inflammation, allergic reaction, pain, nerve damage because of anatomic variations, fainting and high and/or low blood pressure.

I also authorize DR. JOHNSON to photograph me for use in educational and teaching purposes.

Signature:_____Date:_____

Print Name:_____

Insurance Information:

Name of insured Subscriber: _____

Relation to patient: Self _____ Spouse _____ Other _____

Address: _____
Street and Apartment Number

City: _____ State: _____ Zip Code: _____

Home phone: (___) _____ Business phone: (___) _____

SS#: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
Month Day Year

Employer: _____

Primary Dental Insurance:

Company _____ Insurance Phone#: (___) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip:_____ ID#_____

Secondary Insurance:

Subscriber's Name:_____SSN_____ _____ _____

Company _____ Insurance Phone #: (___) _____

Address: _____ Group #: _____

City: _____ State: _____ Zip:_____ ID#_____

I authorize the release of information relating to this claim. The dental office will pre-determine the insurance benefit for treatment, and will submit dental insurance forms as a courtesy to our patients. Insurance payments will be made directly to the insured. I understand that I am responsible for all costs of treatment, and that payment is due and payable according to financial agreements made with this office.

Signature: _____ Date:_____