Confidential Patient Information for the Office of Mark M. Johnston, DDS

Name: Mr. Mrs. Ms. Dr. ______________________ Nickname ____________
Address: ______________________ City ____________ St. ________ Zip ________
Home Phone: ______________ Work Phone: ______________ Other: ______________
Date of Birth: ____/____/____ Soc. Sec. # _____-_____-______
E-mail address ____________________ Drivers License # ______________ St. _______
Are you a full time student? Yes ____ No ____ Where? ______________________
Whom may we thank for referring you to our office? ______________________
Person to notify in case of an emergency: ____________________ Phone # ______________

Will you be requiring credit (financing) by our office for dental care? Yes No
If yes ask for a dental credit card application
How will you be paying for the dental treatment? Please circle

1. Payment in full at time of appointment. (over $1,000.00–10% discount for cash or check.)
2. Credit Card: Visa, Master Card # ____________________ Exp. Date ____________
3. Monthly installments (1% interest per month after 90 days) with approved credit. Please speak with the front desk.

If you have Dental Insurance please fill out below: We will gladly complete your dental insurance forms to help you receive the maximum benefit from your insurance company. Please bring in your insurance booklet so that we can keep it with your chart. Insurance is a contract between the insurance company and the patient, not the dentist. The patient is responsible for all charges of dental care and collection fees.
Name of person with insurance: ____________ Relationship: ________ Employer: __________
Date of Birth: ____/____/____ Soc. Sec # _____-_____-______
Primary: Insurance company name: ______________________ Group # ____________
Mailing address: ______________________________ Phone # ______________
Deductibles: Individual $__________ Family $__________ Maximum $ per year__________
Renewal Date: _________
If you have dental insurance please fill out below:
Name of person with insurance: ____________ Relationship: ________ Employer: __________
Secondary: Insurance company name: ______________________ Group # __________
Mailing address: ______________________________ Phone # ______________
Deductibles: Individual $__________ Family $__________ Maximum $ per year__________
Renewal Date: _________

Authorization: I hereby authorize directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and on the medical history is correct to the best of my knowledge. And I also agree that **if I am financing**, I am giving permission to the permissible purpose rule, which allows a credit report to be run.

Signature ______________________________ **Date** ____________