TODD JOHNSON, DDS

PATIENT REGISTRATION

(Please Print and Complete All Areas)

Patient Legal Name _____
First Middle Last

Prefer to be Called (Nickname) _____

Mailing Address _____

City/State _____ Zip _____

Physical Address (if different) _____

City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Sec # _____ Date of Birth _____

Gender _____M _____F Marital Status _____ Student/Employed/Retired (Circle One)

Email Address _____ (Only to relay appointment information if unable to reach you via telephone)

Employer Name _____ Occupation _____

Referred to us By _____

SPOUSE/PARENT INFORMATION

Name _____ Social Security # _____ Date of Birth _____

Employer Name _____ Work Phone _____ Cell Phone _____

INSURANCE

Primary Insurance Name _____ ID# _____ Group # _____

Subscriber Name _____ Relationship _____ Date of Birth _____

Employer _____

Secondary Insurance Name _____ ID# _____ Group # _____

Subscriber Name _____ Relationship _____ Date of Birth _____

Employer _____

IN CASE OF EMERGENCY PLEASE NOTIFY (SOMEONE OTHER THAN SPOUSE/PARENT FROM ABOVE)

Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

PERMISSIONS

We frequently call our patients for appointment reminders, for treatment concerns and questions, for financial and insurance concerns, and for other issues related to your care in our office. We also mail appointment reminder postcards and letters in attempt to collect debt when necessary. There are federal laws in place that require us to get your permission for these types of communications.

Regarding any and all of the above, may we:

* Phone you at home or call or text your cell phone? O Yes O No
* Leave a message on your answering machine at home? O Yes O No
* Leave a message at your place of employment? O Yes O No
* Contact you via U.S. Mail at the address above? O Yes O No
* Communicate with any member of your household? O Yes O No

If yes, Whom? _____ Relationship to You _____

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services and I understand and agree that co-payments are due at the time of service.

I acknowledge and accept financial responsibility for the payment of all charges for services rendered to the patient listed on the registration form. In the event of default of payment and/or failure to pay, I agree to pay the costs of collection, including all court costs and any reasonable attorney fees to be determined by a court of law.

I understand and agree that any check returned to Dr. Johnson for insufficient funds will be charged a NSF check fee of $30.00.

_____

Patient Signature (or parent/guardian of patient if under age 18) Date

TODD JOHNSON, DDS

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office of Todd Johnson, DDS at (360)533-7120.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Todd Johnson, DDS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, you will be offered a copy of the revised Notice of Privacy Practices at the time of your first visit after the revisions become effective. You may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to you.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual Date

_____

Printed name if signed on behalf of the patient Relationship to patient