W. Frank Johnson, D.D.S., P.C.
1013 Executive Drive, Suite 103 • Hixson, TN 37343 • 423-870-1818

PATIENT REGISTRATION

Welcome to our office! *The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.*

ABOUT YOU

Name _____
LAST FIRST M.I. MR MRS MS DR

I prefer to be called _____

☐ Male ☐ Female Age _____

Birthdate _____ SS# _____

Home Address _____

_____

☐ Minor Child ☐ Single ☐ Married ☐ Widowed

E-mail address _____

Home phone _____ Cell phone _____

Work phone _____

Employer _____

Employer's address _____

Occupation _____

Whom may we thank for referring you? _____

Other family members who are patients _____

_____

Emergency Contact _____

Relationship _____

Home phone _____ Work phone _____

YOUR SPOUSE/PARENT/GUARDIAN

Name _____

Employer _____

Home phone _____ Work phone _____

Birthdate _____ SS# _____

Person Responsible for Account

Name _____

Employer _____

Home phone _____ Work phone _____

Billing Address _____

_____

Relationship _____ SS # _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company _____

Insured's name _____

Work phone _____ SS# _____

Insured's employer _____

Employer's address _____

Relationship to patient _____

Insured's birthdate _____ Group # _____

Secondary Insurance

Insurance Company _____

Insured's name _____

Work phone _____ SS# _____

Insured's employer _____

Employer's address _____

Relationship to patient _____

Insured's birthdate _____ Group # _____

FINANCIAL AGREEMENT

If you have dental insurance — We will gladly file your dental insurance. In cases where benefits cover less than our treatment fee, you are responsible for paying the difference. We will try to estimate your coverage in good faith, but cannot guarantee what your insurer will pay. Please contact your insurance company with any questions you may have. You must pay your insurance co-payment at the time of treatment.

☐ I have dental insurance and will pay my estimated co-pay today by check, cash, or credit card.

If you do not have dental insurance — Please check one of the following options.

☐ I will pay in full on the day of treatment by check, cash, or credit card. Note that treatment of minors is the responsibility of the adult accompanying that minor.

☐ CareCredit, an interest-free three month plan, is available for those with a high approval rating. If interested, please ask for an application.

Signature _____ Date _____

PLEASE NOTE: *Your appointment time is set aside especially for you. We make every effort to honor time commitments and request that you extend the same courtesy to us. We require a 24 hour notification for cancellations or scheduling changes. Without proper notification, a $50.00 broken appointment fee will be assessed and prepayment for services may be required.*

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.