# Johnson Dental

**Patient Information Update**

## UPDATE ALL OF THE FOLOWING INFORMATION

Patient's Name: ______________________________ Date: ______________

***** If Patient Is a child *** ( Parent's Information: )**

Address: ______________________________ City: ____________ State: ________ Zip: ____________

**Home#** ______________________ **Work #** ______________________ **Cell #** ______________________

Marital Status: (Circle One): **Single** **Married** **Divorced** **Widowed** **Child**

**Email:** ______________________________ **Complete The Following For Insurance Information:**

Policy Holder's Name: ______________________ Employer: ______________________

Insured ID#: ______________ **Dental Ins Co Name & Mailing Address:** ______________________________

______________________ Ph#: ______________________ Group, Policy, or Plan # ______________________

**Medical History Update: If You Have Had Any Medical Changes Since Your Last Visit Please Inform Provider When Seated For Your Visit Today! Thank You.**

## OFFICE POLICY FOR JOHNSON DENTAL

### **** Regarding Your Insurance & Insurance Changes ****

We will file your insurance for services where eligibility has been verified as a ***courtesy***. **Insurance verification does not guarantee your insurance will pay for services**. Payments of Co-insurance, deductibles, or fees for non-covered services are ***due at the time services are rendered***. You are responsible for all services rendered regardless of dental insurance. We **REQUIRE** at least **48 hours' notice** ***for changes of appointments and insurance updates*** **& need the updates PRIOR to appointments**. Let our office know **As Soon As Possible of Any & All Insurance changes.**

**I Authorize & Direct payment of dental benefits otherwise payable to me, directly to Dr. Kerry Johnson/Johnson Dental.** I have been informed of treatment & associated fees. I agree to be responsible for all charges for dental services & materials not payable by my dental benefit plan. I consent to your use & disclosure of my protected health information to carry out payment activities in connection with all dental claims.

### Regarding Appointments

We understand that your time is important and we ask that you respect the time of the other patients and doctors. Our office needs **AT LEAST " 24 – 48 " hours' notice** to *cancel* or *reschedule appointments*.

### Pre-Medication

It is your responsibility to provide the name and number of your pharmacy and allergies on your medical history sheet. Pre-medication is necessary if you have been diagnosed with certain heart conditions, also if you have artificial joints (knees, hips, pins) and have been directed to do so by your doctor. **If pre-med is not taken as directed prior to appointment, we will be unable to provide service at that time.**

______________________________________________________________

**Signature** **Date**