horizondentalcare
Bob Johnson, DDS

Patient Information

Name:__________________________________ Preferred Name: __________________________Date: _______________________

Address: ____

street city state zip

Please provide all contact information, and then check best method of contact during working hours:

___ Home Phone: ________________________________ ____ Cell Phone: ____

___ Work Phone: ________________________________ ____ E-Mail Address: ____

Birthdate: ________________ Social Security # ________________________ How long at this Address: _______________________

If patient is a minor, give parent's or guardian's name: ____

Do other members of your family come here? ____

Whom may we thank for referring you to our office? ____

If referred by the internet, which source? (check one) ____ Google Search ____ FaceBook ____ Our website

___ Other (please specify) ____

Do you write internet reviews? If so, where would you most likely post reviews? (check all that apply)

____ Google ____ Yahoo ____ Citysearch ____ Superpages ____ Yellow Pages ____ Yelp ____ Angies List

____ Dexknows ____ Bing ____ Other (please specify)____

Person responsible for Account, if different than above: ____

Address: ____

street city state zip

Social Security #: _______________________ Birthdate: _________________ Relationship to Patient: ________________________

Employer: ___________________________ Occupation: ______________________________ Years Employed: __________________

Spouse's Name: _____________________________________ Birthdate: _________________ Contact #: ______________________

Dental Insurance Information

Insured's Name (Subscriber of Insurance) : ____________________________________ Insured's Social Security #:_______________

Insured's Birth date: _____________________ Insurance Company: ____

Group #:_____________________ ID #: _______________________ Insurance phone # : ____________________________________

Emergency Information

Name of nearest relative not living with you: ____ Phone Number: __________________

Address: ____

I hereby authorize payment directly to Bob Johnson, DDS, of the 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. I acknowledge the opportunity to review this office's privacy policy. The information on this page is correct to my knowledge.

Signature: (Parent's signature if minor): ____