Johnson Orthodontics

TAD. T. JOHNSON • DDS, MS

Patient Information

Date _____

Patient's Name _____ Preferred First Name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Age _____ Birthdate ____/____/____ Social Security # _____

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

If under 18:

School Sports/Hobbies _____

Parent or Guardian Names _____

Responsible Party Information

Parent/Guardian Name (with whom patient lives) _____

Residence _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

How long at this address? _____ Home Phone _____ Work Phone _____

Cell/Other Phone _____ Email Address _____

Previous Address (if less than 3 years) _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Social Security# _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Address _____ City _____ Zip _____

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent/Guardian Signature _____

Update (date/initial) _____