Patient Registration

Submit by Email | Print Form

Today's date: **Date of birth:**

Name:

I prefer to be addressed as:

Home address:

City/state/ZIP code:

Home phone: **Cell:**

Sex: ◯ Male ◯ Female **Marital Status:**

Your SSN:

Your employer:

Employer Address:

City/state/ZIP code:

Employer's phone:

Spouse's name

Spouse's SSN:

Spouse's date of birth:

Spouse's employer:

Employer's address:

City/state/ZIP code:

Phone number:

Emergency contact:

Phone number:

Referred to us by:

Who is responsible for this account?

DR. KEN JOHNSON
FAMILY DENTISTRY

Ken Johnson, DDS
918 E. Park Ave Plaza
Beloit, WI 53511
Phone: (608) 365-9456
www.kenjohnsondds.com
info@kenjohnsondds.com

Office Policies

All patients who no-show for an appointment or cancel without 24-hour advance notice will be charged a $25 fee. Repeat offenders will be required to pay a non-refundable pre-payment of the charges for their next visit or face expulsion from the practice.

Payment is required at the time services are received. If you have insurance, we will estimate your portion due, and ask that you pay that portion at the time of service. Be aware that this is only an estimate!! This office has no control over your insurance carrier's payments.

I hereby authorize payment of insurance benefits directly to the dentist. I understand that my dental insurance carrier may pay less than expected. I understand that I am financially responsible for the full fee for any service received. If the insurance payment is less than expected, I agree to pay the remaining balance within 30 days of receipt of statement, or be subject to the maximum interest allowable by law.

Our office is HIPPA compliant. A copy of this privacy policy is available for you at any time.

I have read and understand these policies. I certify that the above information is complete and accurate.

SIGNATURE _____

DATE _____

Dental Insurance Information

Name of primary insurance company:

Subscriber's name **Subscriber's date of birth:**

Employer: **Subscriber's SSN:**

Policy number: **Group number:**

Name of secondary insurance company:

Subscriber's name **Subscriber's date of birth:**

Employer: **Subscriber's SSN:**

Policy number: **Group number:**

Medical History

General health: **Are you under a physician's care?** ◯ Yes ◯ No

Physician's name: **Date of of last visit :**

Please list any medications you are taking:

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Have you ever had or been treated for any of the following diseases or medical problems?

Alzheimer's/Memory Loss	Fibromyalgia	Pacemaker
Anemia	Gastrointestinal Disorder	Radiation Treatments
Anorexia/Bulimia	Glaucoma	Rheumatic/Scarlet Fever
Arthritis/Rheumatism	Hearing Impaired	Serious Accident
Artificial Heart Valve	Heart Attack	Shingles
Artificial Joint Replacement	Heart Disease	Sinus Problems
Asthma or Hay Fever	Heart Murmur	Smoking/Tobacco Use
Blood Transfusions	Heart Surgery	Snoring/Sleep Apnea
Cancer	Hemophilia	Stroke/TIA
Chemotherapy	Hepatitis A B C D	Thyroid Problems
Chronic Fatigue Syndrome	High Blood Pressure	Tuberculosis
Cold Sore/Herpes	High Cholesterol	Tumor Growth
Depression/Anxiety	HIV/AIDS	Ulcers
Diabetes (Type I or II)	Kidney Problems	Venereal Disease
Drug/Alcohol Abuse	Liver Problems	Other:
Emphysema	Migraines	Other:
Epilepsy/Seizures/Fainting	Mitral Valve Prolapse	Other:

Are you allergic to any of the following?

- ☐ Amoxicillin
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other:
- ☐ Other:

Women:

Are you pregnant?

Do you suspect you might be?

Are you nursing?

Are you taking birth control?

I certify that the above information is complete and accurate.

Date:

Signature **Parent Signature (for minors)**