321 N. Breiel Blvd. 513-424-3971
Middletown, OH 45042

2309 Woodman Dr. 937-252-9070
Kettering, OH 45420

Garland & Johnson Dental

PATIENT WELCOME FORM

Welcome to your new dental home. The information on this form is important for our records and for your health. This information is strictly confidential. Thank you.

PERSONAL INFORMATION

Patient's Legal Name: Last, First Initial_____ Date of Birth _____ ❒Male ❒Female

Preferred Name _____ Home Phone #_____ Cell Phone #_____

Patient's Address: Street, Apt #_____ City_____ State_____ Postal Code _____

Social Security Number_____ Driver's License Number _____

E-mail _____ ❒Minor Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed

If Student, name of School/College _____ City _____ State _____ ❒Full-time ❒Part-time

Patient/Guardian's Employer_____ Occupation_____

Work Address: Street, Ste #_____ City_____ State_____ Postal Code_____ Phone # _____

Spouse's Name: Last, First Initial_____ Spouse's Employer _____ Occupation _____

Spouse's Work Address_____ City_____ State_____ Postal Code_____ Phone # _____

Do you have other family members who are patients here? _____

Who can we thank for referring you to our office?_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship _____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

INSURANCE AND FINANCIAL INFORMATION

Do you have insurance coverage? ❒No ❒Yes - Insurance Company Name_____ Phone #_____

Insured Name _____ SS#_____ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate_____ Group Cert/ID #_____ Division #_____ Group/Policy #_____

Employer (if different from above) _____ Employer Address _____

Do you have secondary coverage? ❒No ❒Yes - Insurance Company Name _____ Phone #_____

Insured Name _____ SS#_____ Patient's Relationship to Subscriber ❒Self ❒Spouse ❒Guardian

Insured Birthdate _____ Group Cert/ID #_____ Division #_____ Group/Policy #_____

Employer (if different from above)_____ Employer Address_____

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RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address: Street, Ste #_____ City_____State_____ Postal Code_____Phone #_____

Home Phone #_____Work Phone #_____Cell Phone #_____

RELEASE INFORMATION

You may discuss my health care with.....

Health Care Providers ❒Yes ❒No Insurance Companies ❒Yes ❒No Others (Spouse, Parents, etc.) _____

_____

_____

ASSIGNMENT AND RELEASE

Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a 'pay-all'. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.

We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days notice, in which case no cancellation fee will be applied.

I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been approved. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I hereby authorize payment directly to GARLAND & JOHNSON DENTAL for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature Patient/Guardian_____Date _____

Witness Signature_____Date _____