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

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

9684 Cincinnati Columbus Rd.
513-777-5369 West Chester, OH 45241

Garland & Johnson Dental

PATIENT WELCOME FORM

Continued from Page 1

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 _____