JOHNSON RANCH DENTAL

2320 Professional Drive
Roseville CA 95661
916-784-1700

PATIENT INFORMATION

info@johnsonranchdental.com
www.johnsonranchdental.com

Today's Date:

NAME: Last First Mi ❑ Male ❑ Female

I prefer to be called: _____

BIRTH DATE: ___/___/___ AGE ____ SS# _____

❑ Single ❑ Married ❑ Student: School _____ in _____ City

HOME ADDRESS _____

City State ZIP

HOME PH#: _____ CELL _____

WORK PH#: _____ EXT _____

E-MAIL ADDRESS: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

HOW LONG? _____ OCCUPATION _____

REASON FOR VISIT:

_____

WHERE AND WHEN ARE BEST TIMES TO REACH YOU

_____

OTHER FAMILY MEMBERS SEEN BY US

SPOUSE INFORMATION
(Parent or Guardian, if Patient is a MINOR)

NAME: _____

EMPLOYER: _____

WORK PH# _____ EXT: SS# _____

BIRTH DATE: ___/___/___ DL# _____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT

_____

_____

WORK PH# EXT: HOME PHONE#

BILLING ADDRESS

_____

RELATIONSHIP: _____ SS# _____

EMPLOYER: _____

DL#: _____

PREFERRED METHOD OF PAYMENT: ❑ CASH ❑ CHECK ❑ BANK CARD

EMERGENCY CONTACT

NAME: _____

RELATION: _____

WORK PH# _____ HOME PH# _____

PERSONAL UPDATE:

HOW DID YOU BECOME OUR PATIENT

- ❑ INTERNET
- ❑ EMERGENCY
- ❑ YELLOW PAGES
- ❑ LOCAL PROMOTION _____
- ❑ PERSONAL REFERRAL*
- ❑ other _____

* Is there someone we should thank for referring you to our practice?

_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

EMPLOYEE'S NAME: _____

EMPLOYEE'S S.S.#: _____

EMPLOYEE'S BIRTHDATE: _____

RELATION TO PATIENT: _____

INSURANCE CO: _____

INS. CO ADDRESS: _____

_____

INS. CO PHONE#: (____) _____ ZIP

GROUP # / ID #: _____ / _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

_____

EFFECTIVE DATE: _____ ZIP

SECONDARY DENTAL INSURANCE

EMPLOYEE'S NAME: _____

EMPLOYEE'S S.S.#: _____

EMPLOYEE'S BIRTHDATE: _____

RELATION TO PATIENT: _____

INSURANCE CO: _____

INS. CO ADDRESS: _____

_____

INS. CO PHONE#: (____) _____ ZIP

GROUP # / ID #: _____ / _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

_____

EFFECTIVE DATE: _____ ZIP