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: ____________

ZIP

INS. CO PHONE#: (   ) ____________

GROUP # / ID #: ________ / ________

INSURED'S EMPLOYER: ____________

EMPLOYER'S ADDRESS: ____________

ZIP

EFFECTIVE DATE: ____________

SECONDARY DENTAL INSURANCE

EMPLOYEE'S NAME: ____________

EMPLOYEE'S S.S.#: ____________

EMPLOYEE'S BIRTHDATE: ____________

RELATION TO PATIENT: ____________

INSURANCE CO: ____________

INS. CO ADDRESS: ____________

ZIP

INS. CO PHONE#: (   ) ____________

GROUP # / ID #: ________ / ________

INSURED'S EMPLOYER: ____________

EMPLOYER'S ADDRESS: ____________

ZIP

EFFECTIVE DATE: ____________