NORTH VALLEY CENTER
FOR ORAL AND IMPLANT SURGERY
Caring, compassionate, and precise
DR. DONALD JOHNSON

Patient Information Form

Date _____

Patient: (Mr., Mrs., Ms., Dr.) Last Name _____ First Name _____ M.I. _____

Home Address: _____ City _____ State _____ Zip _____

Home Tel. # (_____) _____ Business Tel. # (_____) _____ Ext. _____ Employer _____

Cell Phone # (_____) _____ Date of Birth _____ Age _____ Soc. Sec. # _____

Sex: Male _____ Female: _____ Height: _____ Weight: _____

Driver's Lic. # _____ Have you ever been a patient of our practice? Yes _____ No _____

Student: Full Time _____ Part Time _____ Not _____ School Name/Address _____

Who will be responsible for your account? Self_____ Spouse_____ Father_____ Mother_____ Other_____

Name _____ Soc. Sec. # _____ Cell Phone # (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. # (_____) _____

Primary Dental Insurance Company

Employer _____

Ins. Co. Name _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: M____ F_____ Date of Birth _____

Street _____

City, State, Zip _____

Tel. # (____) _____ S.S.# _____

I.D.# _____

Secondary Dental Insurance Company

Employer _____

Ins. Co. Name _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: M____ F_____ Date of Birth _____

Street _____

City, State, Zip _____

Tel. # (____) _____ S.S.# _____

I.D.# _____

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my dentist.

X _____ Date: _____