Timothy S Johnston, MD & Associates

PATIENT INFORMATION

PLEASE PRINT:

COMPLETE THIS SECTION ON THE PATIENT BEING TREATED

PRIMARY LANGUAGE SPOKEN:______________________ CELL: (_____) ______________

RACE: ______________ ETHNICITY: ______________ EMAIL:______________________

PATIENT NAME: ______________________________________ AGE: _________ BIRTHDATE: ____________
(last) (first) (initial)

ADDRESS:______________________ CITY: ____________ ZIP: __________ PHONE: (_____) ____________

SEX: _________ MARITAL STATUS: ____________ SOC. SEC. NO.: ______________ PATIENT OCCUPATION:______________

COMPLETE THIS SECTION ON PERSON RESPONSIBLE FOR PAYMENT

NAME: ______________________________________ BIRTHDATE:____________

ADDRESS:______________________ CITY: ____________ ZIP: __________ PHONE: (_____) ____________

RELATIONSHIP TO PATIENT: ______________ SOC. SEC. NO.: ______________ DR. LIC. NO.: ______________

EMPLOYER: ______________________ OCCUPATION:______________ ______________

EMPLOYER ADDRESS: ______________________ ZIP: __________ PHONE: ____________

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:______________________ PHONE: ____________

RELATION TO PATIENT: ______________ ADDRESS: ______________________ CELL: (_____) ____________

INSURANCE INFORMATION MUST BE COMPLETED FOR US TO PROCESS YOUR INSURANCE CLAIM

PRIMARY INSURANCE COMPANY:______________________ ID#: ____________ GRP.# ____________

INSURED NAME:______________________ D.O.B. ____________RELATION TO PATIENT: ____________

INSURED ADDRESS: ______________________ ZIP:__________ PHONE: (_____) ____________

SOC. SEC. NO.: ______________________ EMPLOYER:______________________

EMPL. ADDRESS:______________________ PHONE: (_____) ____________

SECONDARY INSURANCE COMPANY:______________________ ID#: ____________ GRP.# ____________

INSURED NAME:______________________ D.O.B. ____________RELATION TO PATIENT: ____________

INSURED ADDRESS: ______________________ ZIP:__________ PHONE: (_____) ____________

SOC. SEC. NO.: ______________________ EMPLOYER:______________________

EMPL. ADDRESS:______________________ PHONE: (_____) ____________

PAYMENT IS REQUESTED BY CASH, CHECK OR CREDIT CARD AT THE TIME OF TREATMENT.

As a courtesy, we will bill your insurance for you if:

1) You have **verifiable** insurance (ID Card or completed, signed form).
2) Appropriate co-payment is made at the time of service.

THIS BILL IS YOUR RESPONSIBILITY.

PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE COVERAGE.

AUTHORIZATIONS

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE. I AUTHORIZE ANY MEDICAL TREATMENT, ANESTHETICS OR SURGICAL PROCEDURES AS THE ATTENDING PHYSICIAN DEEMS NECESSARY.

I HEREBY AUTHORIZE TIMOTHY S JOHNSTON, MD & ASSOCIATES TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF CHARGES INCURRED IN THE COURSE OF TREATMENT AT TIMOTHY S JOHNSTON, MD & ASSOCIATES. Should this account become delinquent and be referred to an attorney or collection agency for collections, the undersigned will pay actual attorney's fees and collection expenses.

Signatures: Date ______________ Patient or Parent (if minor) ______________________ ______________________