

BARRY JOHNSIN, D.D.S., INC. TRENT WESTERNOFF, D.M.D., M.D.
ORAL & MAXILLOFACIAL SURGERY
DENTAL IMPLANTS
1706 S. ELENA AVENUE, SUITE A
REDONDO BEACH CA 90277

PATIENT INFORMATION

Male / Female (circle one)		Today's Date _____	
Have you or any member of your family been to our office before? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name: Last	First	Mi	Birthdate
Mr. Mrs. Ms. Dr.		Age	Driver Lic. #
Home Address		City	State
		Zip Code	Telephone
Cell Phone #	Pager #	E-mail Address	
What would you prefer to be called (e.g. "Mrs. Smith," "Bob")?			
Social Sec. Number	Marital Status (circle one)		Spouse Name
	Sgl M W D Sep		
If patient is a minor:	Father's name	Mother's name	
In Case of Emergency Name:	Relationship		Telephone #
Student? Full time <input type="checkbox"/>	Part time <input type="checkbox"/>	School Name: _____	
School Address: _____			
Do you have Dental Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		IF YES, PLEASE COMPLETE INSURANCE INFORMATION FORM	
Do you have Medical Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		REVERSE SIDE	
Person responsible for payment of services other than insurance (if not patient):			
Name	Address	Telephone #	Relation to patient
Whom may we thank for referring you?	General Dentist	Telephone #	
Physician	Address	Telephone #	
Reason for seeking treatment:			

PATIENT EMPLOYMENT INFORMATION

Place of Employment	
Position	How long?
Address	City
State	Zip Code
Business Telephone #	

INSURANCE INFORMATION

Primary Subscriber		Secondary Subscriber	
Subscriber's name _____ Date of birth _____		Subscriber's name _____ Date of birth _____	
Relationship to Patient (Circle one) Self Spouse Parent Other		Relationship to Patient (Circle one) Self Spouse Parent Other	
SS# of subscriber _____	Group # _____	SS# of subscriber _____	Group # _____
Occupation _____		Occupation _____	
Employer _____	Employee ID# _____	Employer _____	Employee ID# _____
Work Address _____ Phone _____		Work Address _____ Phone _____	

Primary Dental Insurance		Secondary Dental Insurance	
Insurance Company _____		Insurance Company _____	
Mailing Address for claims _____		Mailing Address for claims _____	
City _____	State _____ Zip _____	City _____	State _____ Zip _____
Telephone # for claims _____		Telephone # for claims _____	
Group name & number _____		Group name & number _____	

Primary Medical Insurance		Secondary Medical Insurance	
Insurance Company _____		Insurance Company _____	
Mailing Address for claims _____		Mailing Address for claims _____	
City _____	State _____ Zip _____	City _____	State _____ Zip _____
Telephone # for claims _____		Telephone # for claims _____	
Group name & number _____		Group name & number _____	

FEES AND PAYMENTS

Fees and co-payments are due at the time services are rendered. We accept cash, checks, money orders, MasterCard, Visa, and Discover Card. Our returned check charge is \$15.00.

We will be happy to help process your insurance claim. In most instances, we will accept assignment of benefits. We do ask for partial payment at the time of services. Please remember that insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. All co-payments are an estimate only based on information provided to us by your insurance company. Not all services are covered by every insurance contract. Some insurance companies arbitrarily select certain services they will not cover. **It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your insurance company.** Occasionally, dental insurance companies require that we first bill a patient's medical insurance. Because of the long delay in receiving payment, we ask 50% of fee be paid at the time of procedure. A prompt refund will be made for any amount that we receive from the insurance carrier.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

This signature on file is my authorization for the release of any information necessary to process my claim. I hereby authorize payment to Redondo Oral Surgery of the benefits otherwise payable to me. I have read and understand the preceding information.

Signature Primary Insured _____ Date _____

Signature Secondary Insured _____ Date _____