JOHNSTON ORTHODONTICS, LLC

Responsible Party Information

Please fill out all information completely.

Name:_________________________ Relationship to Patient:_______________________

Address:____

Mailing Address **(No PO Boxes)** City State Zip

Home Phone:______________ Work Phone:_____________ Date of Birth:_______________

Marital Status:______________ Social Security:_________________

Employer:__________________ Occupation:____________________

Employer's Address:____

Street Address City State Zip

Spouse's Name:_____________________ Spouse's Social Security:____________________

Spouse's Employer:_______________ Work Phone:___________ Date of Birth: _________

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Insurance Information

Dental (Primary):

Subscriber's Name:___________________ Subscriber Social Security:__________________

Insurance Company:________________ Group No.:___________ Phone No.:_____________

Insurance Company Address:____

Mailing Address City State Zip

Subscriber's Employer:_____________________Subscriber's Date of Birth: ______________

Dental (Secondary):

Company Address:____

Subscriber's Name:__________________ Subscriber Social Security:___________________

Insurance Company:________________ Group No.:___________ Phone No.:_____________

Insurance Company Address:____

Mailing Address City State Zip

Subscriber's Employer:_______________________Subscriber's Date of Birth: ____________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to the patient and to file insurance on the patient's behalf. I authorize and request my insurance company to pay directly to Johnston Orthodontics benefits otherwise payable to me. ***Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. If you lose your insurance coverage for any reason, you are responsible for the unpaid balance of the insurance coverage. Please note that there is a $50.00 fee on all returned checks.*** *We don't do double discounts*. A photocopy or facsimile of this assignment is considered to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. ***After the account becomes two months delinquent, I understand that the treatment can be placed on emergency treatment only basis until account is brought current. If that cannot be achieved, removing the appliance(s) and/or braces will be considered*.** **Should the account be referred to an agency or attorney for collection (at 90 days past due), the undersigned shall pay the agency's fees of 40% and reasonable attorney's fees and collection expenses.**

Notice: *We alternate during school and after school appointments. If you miss an after school appointment, the next two appointments are automatically during school. Also, there are some appointments that are only done at certain times of the day due to the length and type of procedure.*

Patient or Guardian's Signature ____________________________ Date ______________