Alaska Smiles
FAMILY & COSMETIC DENTISTRY
Brett C. Johnson DDS

PATIENT REGISTRATION

First Name:_____ Middle Initial:_____

Last Name:_____Preferred Name:_____

Patient is: □ Responsible Party □ Policy Holder

Patient Information

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Birth date:_____Social Security #:_____Drivers Lic# & State:_____

E-mail:_____□ I would like to receive email correspondences

Responsible Party: (if someone other than the patient)

Name:_____

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____Social Security #:_____Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Whom may we thank for referring you?_____

Primary Insurance Information:

Name of Insured:_____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Subscriber ID: _____Group #:_____
Insured Social Security #:_____Insured Birth date:_____
Employer:_____Insurance Company:_____
Address:_____Address:_____
Address 2: _____Address 2:_____
City, State, Zip:_____City, State, Zip:_____

Secondary Insurance Information:

Name of Insured:_____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Subscriber ID: _____Group #:_____
Insured Social Security #:_____Insured Birth date:_____
Employer:_____Insurance Company:_____
Address:_____Address:_____
Address 2: _____Address 2:_____
City, State, Zip:_____City, State, Zip:_____