William A. Johnson, DDS

South Indy Dental, PC

5217 Commerce Circle, Indianapolis, IN | P: (317) 881-5000 | F: (317) 881-5006

www.smilesouthindy.com | southindydentalpc@gmail.com

New Patient Registration

Full Name: _____ Preferred Name: _____

Full Address: _____

Preferred Phone: (___)_____ Home | Work | Cell SSN: _____

Other Phone: (___)_____ Home | Work | Cell DOB: _____/_____/_____

E-mail Address: _____

How did you hear about our office? _____

_____

Primary Dental Insurance

Policyholder's Name: _____ DOB: ___ /___/_____

Full Address: _____

Employer Name: _____ Insurer: _____ Group #: _____

SSN: _____ Subscriber ID #: _____ Relationship to Patient: _____

Secondary Dental Insurance

Policyholder's Name: _____ DOB: ___ /___/_____

Full Address: _____

Employer Name: _____ Insurer: _____ Group #: _____

SSN: _____ Subscriber ID #: _____ Relationship to Patient: _____

Acknowledgement of Financial Responsibility

I understand that full payment is due at the time of service unless other arrangements have been made in advance. I understand that, while South Indy Dental will make every reasonable effort to obtain reimbursement through insurance, any fees not reimbursed by insurance or other third parties remain my obligation to pay. In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

Signature: _____ Date: _____

Printed Name: _____