Johnson Dentistry
410 West Main Street
Plainfield, IN 46168
317-839-3502

Full Name_____Date of Birth_____ Age_____

Marital Status_____Social Security #_____

Address_____City, St, Zip_____

We have an automated system that will call, text, or email for appointment confirmations. Please let us know your preference. *If you have a home phone and it is through a cell phone company (i.e. ATT, Verizon) please choose a different method because the automated system will try to text your house!

(__ __ __) __ __ __-__ __ __ __ (Home/Cell/Work)

If you prefer Email_____

Do you have dental insurance coverage? YES NO

Insurance Company_____Group #_____

Members Name_____ID#_____

Insurance Phone # (__ __ __) __ __ __-__ __ __ __

Who should we contact in case of an emergency? Name_____

Relation_____ Phone (__ __ __) __ __ __-__ __ __ __

Who may we thank for referring you to our office?_____

Privacy Practice Documentation

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name:_____ Birth-date:_____

Signature:_____ Date:_____

***A $40 cancellation fee will be charged for appointments canceled with less than 24 hour notice.**

Signature_____ Date_____