



Douglas M. Johnson, D.M.D.
 General Dentistry
 2380 14th Ave. SE, Albany (541) 928-5414
 Scio Memorial Clinic (503) 394-3345

PATIENT INFORMATION

Name: Last _____ First _____ M.I. _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Date Of Birth _____ Social Sec# _____
 E-mail Address _____
 Employer _____ Occupation _____
 Parent's or Guardian's name, if patient is a minor: _____
 If student, name of school attending: _____
 Is another member of your family or a relative a patient in our office? _____
 Whom may we thank for referring you to our office? _____

Responsible Party Information (if different from above)

Name: Last _____ First _____ M.I. _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Date Of Birth _____ Social Sec# _____
 E-mail Address _____
 Employer _____ Occupation _____

Primary Dental Insurance Information

Company _____ Group# _____ Local# _____
 Address _____ City _____ State _____ Zip _____
 Phone# _____
 Employee name _____ Relationship to Patient _____
 Employer _____ Occupation _____
 Date of Birth _____ Social Sec# _____

Secondary Dental Insurance Information

Insurance Company _____ Group# _____ Local# _____
 Address _____ City _____ State _____ Zip _____
 Phone# _____
 Employee name _____ Relationship to Patient _____
 Employer _____ Occupation _____
 Date of Birth _____ Social Sec# _____

Emergency Contact Information

Name: Last _____ First _____ M.I. _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Relationship to Patient _____

I, the undersigned, understand that I am financially responsible for all charges. All fees are to be paid in full at the time of service, unless prior arrangements have been made.

 Patient or Guardian Signature

 Date