Keith Blankenship, D.D.S.
Paul David Johnson, D.M.D., M.S.

Specialists in Orthodontics for Children, Teens & Adults

Serving Flagler County & Palm Coast Full Time since 1999

PATIENT INFORMATION

Patient's Name:	**Preferred Name:**	Today's Date:
Sex: ☐ Male ☐ Female		Date of Birth:
School and Grade:		Age:
Home Address: City/State/Zip		Home Phone: Patient's Email:
School/Hobbies:		
Whom may we thank for referring you:		General Dentist:

FAMILY INFORMATION

Responsible Party #1:		Responsible Party #2:	
DOB:	S.S.#	DOB:	S.S.#
Home Address: *(if different from patient)*		Home Address: *(if different from patient)*	
Home Phone:		Home Phone:	
Employer:		Employer:	
Work Phone:		Work Phone:	
Email Address:		**Email Address:**	
Please list other family members treated here:			

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible:	Date of Birth:
Relationship to Patient:	Social Security Number:
Home Address: *(if different from patient)*	Home Phone: Work Phone:
Employer:	**Email Address:**

RESPONSIBLE PARTY'S INSURANCE INFORMATION

Do you have orthodontic coverage for this child? ☐ Yes ☐ No	Employer:
Insurance Company:	Insured's Name:
Relationship to Patient:	Insured's Date of Birth:
Insurance Claims Address:	Social Security # (required): Ins. ID #
Insurance Company Phone:	Ins. Group #

Financial Information/ Signature Requirement

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and/or deductibles that my insurance does not cover.

_____

Signature of Parent or Guardian **Date**

This office reserves the right to verify credit of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature of Parent or Guardian **Date**

Treatment Authorization Signature Requirement

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian **Date**

For Office Use ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

Doctor's Initials: **Date:**

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How did you hear about us?

___ Friend Referral (_____)

___ Facebook ___ Instagram ___ Mailer

___ Google ___ Other (_____)