Dr. Erik Johnson, DMD

Discounted/Sliding Fee Application

Name of Head of Household: _____Place of employment:_____
Address:_____City: _____State: _____Zip: _____Phone: (____)_____
Health insurance plan: _____Social security number:_____

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		*Dependent*	
Spouse		*Dependent*	
Dependent		*Dependent*	
Dependent		*Dependent*	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment and dependents				
Rent, interest, dividend, and other income				
Total Income				

I certify that the family size and income information shown above is correct. Copies of tax return, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print)_____Date:_____
Signature_____

O**ffice Use Only**

Patient Name_____Discount_____
Date of Service_____Approved by_____

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security care or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		