SUNDENTALDESIGN
Family & Cosmetic Dentistry

PATIENT REGISTRATION

Name_____ DOB_____ ☐ Male ☐ Female
Last First MI Preferred Name

If Child, Parent's Name _____

Single ☐ Married ☐ Widowed ☐

HOME ADDRESS:

Street _____

City_____ State_____ Zip_____

Cell Phone (_____)_____

Home Phone (_____)_____Wk Phone (_____)_____

E-mail _____

Patient/Parent Employer _____

Present Position _____

How Long Held _____

Who is Responsible for this Account? _____

Driver's License No. _____

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card

Other Family Members in this Practice_____

_____

Whom may we thank for this referral? _____

Patient/ Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency _____

_____

DENTAL INSURANCE - PRIMARY

Subscriber's Name_____ DOB _____

Relationship to Patient_____

Insurance Co._____

Insurance Co. Telephone _____

Group #_____

Identification #: _____

DENTAL INSURANCE - SECONDARY

Subscriber's Name_____ DOB _____

Relationship to Patient_____

Insurance Co._____

Insurance Co. Telephone _____

Group #_____

Identification #: _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

_____

PATIENT OR GUARDIAN'S SIGNATURE DATE