SENSITIVE CARE
COSMETIC & FAMILY DENTISTRY

PATIENT REGISTRATION

Date: ______________

First Name: ________________________________ Last Name: ______________________________________

Patient is: ❍ Policy Holder ❍ Responsible Party Referred by: _______________________________

Patient Information

Address: __________________________________ City: __________________ State/Zip: ________________

☐ Hm. # ( )______________________ ☐ Work# ( )_____________________ ext. ________

☐ E-Mail: _____________________________ ☐ Cell # ( ) _____________________________

Birth Date: _______________ Age: ______ SS#: ______________________ Drivers Lic #: ________________

Sex: ❍ Male ❍ Female Martial Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Responsible Party

[For minors only, the guardian which establishes the patient account]

First Name: ________________________________ Last Name: ______________________________________

Address: __________________________________ City: __________________ State/Zip: ________________

Hm. # ( )___________________ Work # ( )_________________ Cell # ( )___________________

Birth Date: _____________ SS#: ____________________________ Drivers Lic #: ______________________

❍ Responsible party is also Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Policy Holder

Primary Insurance Information

Name of Insured: _____________________________

Insured SS#: ___________________D.O.B._______

Employer: ___________________________________

Ins Company: _______________________________

Relationship to patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Secondary Insurance Information

Name of Insured: _____________________________

Insured SS#: ___________________D.O.B._______

Employer: ___________________________________

Ins Company: _______________________________

Relationship to patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1% finance charge maybe added to my account, in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my social security number to file my dental claim.

Patient/Guardian Signature: ____ Date: _______________