SAC DENTIST

Patient Registration Form

WELCOME! We are pleased to have the opportunity to provide excellent service to you. Please take a few moments to complete this form. If you any questions we'll be glad to help you.

Patient Information

Name: Birth date:

SSN: Gender:

Male Female

Address:

Email: Home Phone: ( )

Work Phone: ( ) Cell phone: ( )

I prefer an appointment reminder via:

Text message Email Phone call

Do others in your family come here?

Name(s):

Emergency Contact

Name(s): Telephone: Relationship:

How did you hear about us?

(If someone referred you, please write their name so we can thank them.)

Insurance Information

Primary	**Secondary**
Subscriber name:	Subscriber name:
DOB: SSN:	DOB: SSN:
Insurance:	Insurance:
Employer: Group#:	Employer: Group#:
Relationship to patient:	Relationship to patient:

I authorize the dentist or staff to take x-rays, diagnostic models, photographs, and other diagnostic aids deemed appropriate to make a diagnosis of my dental health needs. I authorize the dentist and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer reviews, educational purposes, billing of charges, legal and collection actions.

I authorize the dentist or staff to perform mutually agreeable treatments utilizing such assistance as the doctor deems necessary.

I agree to use the anesthetics or other medications as necessary for my treatment. I fully understand that using medications have certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. **PAYMENT IS DUE AT THE TIME OF SERVICE**.

I have read and reviewed the office's **NOTICE OF PRIVACY PRACTICE** and **STATE OF CALIFORNIA DENTAL MATERIALS FACT SHEET** available on the Laurel Hills Dental website: www.SacDentist.com under the "Patient Center" tab and/or in the office.

CANCELLATIONS/NO-SHOWS:

We respectfully request a 48 hour notice and require a 24 hour notice for any cancellations or changes to your appointment in advance. If an appointment is not cancelled at least 24 hours in advance you will be charged a Fifty dollar ($50) fee; this will not be covered by your insurance company. Following the act of the cancellation policy, we will require a 10% deposit to secure any future appointments.

I understand the Laurel Hills Dental appointment arrangement and agree to follow the terms of the policy. _____

(Initial)

I consent to Laurel Hills Dental using my cell number to text me regarding my appointments and to call me regarding treatment, insurance or my account.

Yes **No**

PATIENT or GUARDIAN signature Date