sonrisa™
a periodental spa

Patient Registration

Date			
Last Name	First	M.I.	
Prefers to be called by			
Address			
City	State	Zip	
Home Phone No.			
Cell	E-mail		
Birthdate	Age	Male ☐	Female ☐
Married ☐	Single ☐	Divorced ☐	Widowed ☐
Social Security No.			

Account Information

Person Financially Responsible For Account			
Name			
Relationship To Patient		Social Security No.	
Address			
City	State	Zip	
Phone No.			

Dental Insurance

Primary Carrier	
Insurance Company	
Group No.	
Employer's Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's I.D. No.	
Insured's Social Security No.	

Secondary Carrier	
Insurance Company	
Group No.	
Employer's Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's I.D. No	
Insured's Social Security No.	

Getting to know you		
Is Another Member Of Your Family Or Relative A Patient at Our Office? Name:		
Relationship:		
You were referred to us by		
Name:		
Person to Contact For Emergency		
Name:		
Cell Number		
Home Number		
Address		
City	State	Zip

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (Type Patient's Name here) Type Name Of Patient Here dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to proved quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature Date

Parent/ Responsible Party's Signature

Relationship to patient