PATIENT REGISTRATION

PATIENT INFORMATION Today's Date_____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Partnership

Address_____City_____State_____Zip Code_____

Home Phone_____ Cell Phone _____Email_____

Spouse, partner or parent name: _____

How did you hear about us? (Dentist, Friend, Family, Internet, Social Media): _____

EMERGENCY CONTACT NAME: _____ Phone _____

PERSON RESPONSIBLE FOR THE BILL (if different from previously listing) Relationship to patient: _____

Name: _____ Date of Birth: _____/_____/_____

Address_____City_____State_____Zip Code_____

Home Phone_____ Cell Phone _____ Email_____

Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name: _____

Subscriber Name: _____ Group #: _____ID #: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Secondary Insurance Company Name: _____

Subscriber Name: _____ Group #: _____ID #: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

AUTHORIZATION AND RELEASE: I certify that I am over 18 years old or signing on behalf of a minor, assuming fully responsible for all charges. I understand that for treatments not covered by insurance, deductibles, and estimated fees are due at time of treatment. Sun Dental Bellevue does not guarantee insurance payments. With my signature, I hereby authorize and request my insurance benefits be paid directly to Dr. Sun. I authorize Dr. Sun to disclose relevant information, including diagnoses and treatment records, to third-party payors and healthcare practitioners during my dental care. I consent to Sun Dental Bellevue maintaining the privacy of my healthcare information, including not disclosing it to external sources without my consent, even for treatments not covered by my insurance policy. Additionally, I agree that information regarding uncovered treatments will remain within this office.

First Name (Print) _____ Last Name (Print) _____

Signature: _____ **Date:** _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other

Thank you for selecting our dental healthcare team and taking the time to fill out our registration form!