Sunrise Dental Center – Bella Terra | 7777 Edinger Ave. #106, Huntington Beach, CA 92647
Ph: (714) 890-1700 | Fax: (714) 890-1701 | www.SunriseDDS.com

sunrise DENTAL at Bella Terra

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status** (circle one) **Single / Mar**
Home phone ( ) -	**Cell phone** ( )		**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Driver's License #	**Email Address** @				**Work phone** ( )
Street address:	**City:**		**State:**	**ZIP Code:**	

Referred to clinic by (please check one box): ❑ **Dr.** ❑ **Insurance Plan**

❑ **Walk-In** ❑ **Family NAME:** ❑ **Friend NAME:** ❑ **Print Ads Poster, Coupons** ❑ **Yelp** ❑ **Google** ❑ **Other Online**

- **Purpose of initial visit?** _____
- **How long since you last dental visit?** _____
- **What was done at the time?** _____
- **Have you ever had any problems or complications with previous dental treatment?** _____
- **Do you have any questions or concerns?** _____

Employment Information

Employer Name: _____ **Occupation** _____

Are you insured with thru this employer? _____ **If so, what is the insurance companies name** _____

Phone Number ( ) _____ **Name of subscriber (if different from patient)** _____

Social Security # _____ **necessary for insurance purposes only Subscriber Birthdate** _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will reimburse full payment to patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of 30 days from the date of the patient examination. In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to, by me in writing, within the time for payment thereof. I further agree that waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Sunrise Dental Center has permission to use diagnostic and treatment photographs and models of the patient for the purpose of scientific articles, seminars and presentations.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

_____ _____

Signature of patient, parent, guardian or responsible party — Date