Carlos E. Sanchez, D.D.S.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Patient Information

1 _____

Last Name **First Name** **M.I.**

Title : ☐ Mr. ☐ Mrs. ☐ Ms.

Patient Address:_____

City:_____State____Zip_____

Home Phone:_____Work:_____

Cell Phone:_____Pager:_____

Email:_____

Date of Birth:_____ Sex: ☐ Female ☐ Male

☐ Single ☐ Married ☐ Divorced ☐ Child

SS#:_____ DMV#_____

Relationship To Responsible Party: ☐ Self ☐ Spouse ☐ Dependant

Reason For Appointment:_____

Referred By: _____

Patient's Employer:_____

Patient's Occupation_____

Employer's Address:_____

City:_____State____Zip_____

Financially Responsible Party

2 _____

Last Name **First Name** **M.I.**

Title: ☐ Mr. ☐ Mrs. ☐ Ms.

Address:_____

City:_____State____Zip_____

SS#:_____ DMV#_____

Phone:_____Work:_____

Date of Birth: _____

Employer: _____

Occupation_____

Employer's Address:_____

City:_____State____Zip_____

DENTAL INFORMATION

3 We will be happy to bill your insurance company for you. However, it is **EXREMELY** IMPORTANT that we have ALL of your insurance information.

Primary Carrier:

Insurance Co. Name:_____

Insured's Name:_____

Insured's S.S. _____

Insured's Employer:_____

Insured's Date of Birth:_____

Patient's Relation to Insured:_____

Group I.D._____

Do you have any other Dental Insurance?

Yes ☐ No ☐

Secondary Carrier

Insurance Co. Name:_____

Insured's Name:_____

Insured's S.S. _____

Insured's Employer:_____

Insured's Date of Birth:_____

Patient's Relation to Insured:_____

FINANCIAL AGREEMENT / ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent. I further agree that I am responsible for the entire amount of dental and surgical expense, should the nature of the treatment be such that it is not entirely covered by my policy. A Photostat of this authorization shall be valid as the original.

CANCELLATION / NO SHOW POLICY

*I understand that there will be no charge to reschedule appointments if I give a **24 hour advance notice during business hours**. Otherwise I will be subject to a **$25 fee per 1/2-hour for not showing or canceling the day of my appointment.** Please sign below that you have read and understand the above policies.*

Signed:_____**Date**_____