# Lutherville Cosmetic and Family Dentistry

John A. Sawchuk, D.D.S.

## New Patient Registration

### Patient Information

Last Name: _____ First: _____ M.I.: ____ Birth Date: _____
Address: _____ Social Security #: _____ Sex: ____
City/St/Zip: _____ Home Phone #: _____ Cell: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Email: _____
Employer: _____ Work Phone #: _____
Address: _____ City/St/Zip: _____

### Spouse Information

Last Name: _____ First: _____ M.I.: ____ Birth Date: _____
Address: _____ Social Security #: _____ Sex: ____
City/St/Zip: _____ Home Phone #: _____ Cell: _____
Employer: _____ Work Phone #: _____
Address: _____ City/St/Zip: _____

### Guarantor Information

**(if different from patient)**

Last Name: _____ First: _____ M.I.: ____ Birth Date: _____
Address: _____ Social Security #: _____ Sex: ____
City/St/Zip: _____ Home Phone #: _____ Cell: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Email: _____
Employer: _____ Work Phone #: _____
Address: _____ City/St/Zip: _____

### Dental Insurance Information

Primary Insurance Carrier: _____
Name of Policy Holder/Subscriber: _____
Member #: _____ Group #: _____ Plan #: _____
Secondary Insurance Carrier: _____
Name of Policy Holder/Subscriber: _____
Member #: _____ Group #: _____ Plan #: _____

### Other Information

Whom may we thank for referring you?_____
Relative not living with you to contact in case of an emergency: _____
Address: _____
City/St/Zip: _____ Home Phone #: _____

## Financial Agreement and Authorization for Treatment

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay 25% collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

Signed (patient): _____ Date: _____

Signed (guarantor):_____ Date: _____