WELCOME TO 6TH SENSE DENTAL!

We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. We're happy to assist you if you have any questions!

Patient Information (Confidential)

Name____ Preferred Name______________

Birthdate______________ Male___ Female___ Social Security #:____________________

Home#: ________________________ Cell#: ______________________________

Work #:_____________________ E-Mail:____

Preferred Contact Method: ____

Address:____

____

City____ State________ Zip___________________

Minor (child): _________ Single _________Married _________,

Name of Spouse _______________________________ Divorced ______ Widowed ______

If full time student, name of **school** ____

Employer___________________________________City:_________________State:________

Are any other family members patients at 6th Sense Dental? Yes _____No _____

How do you plan to take care of this account? Cash/Check/Credit Card?

Wish to discuss payment options? ____

How did you hear about us? ____

Nearest person not living with you whom we may call in case of an emergency:

_______________________________Relationship ______________ Phone _________________

INSURANCE: LEAVE BLANK IF YOU HAVE NO INSURANCE

Name of Insured Person___________________________________ Birthdate: ________________

Relationship to patient ______________________ Social Security # ________________________

Date employed ______________ Work phone ______________________

Name of employer ____

Address of employer____

City ___________________________ State _______ Zip ______________

Insurance Company ____ Phone#_________________

Group # ____________________________ Union or Local # ____________________

Insurance Co. address ____

City__________________________ State ________ Zip _______________

If you have ADDITIONAL INSURANCE:

Name of Insured Person___________________________________ Birthdate: ________________

Relationship to patient ______________________ Social Security # ________________________

Date employed ______________ Work phone ______________________

Name of employer ____

Address of employer____

City ___________________________ State _______ Zip ______________

Insurance Company ____ Phone #:________________

Group # ____________________________ Union or Local # ____________________

Insurance Co. address ____

City__________________________ State ________ Zip _______________

I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to my child or me during the period of such Dental care to third party payers and/or health practitioners. I understand I am responsible for any and all payments at the time of treatment. If 6th Sense Dental seeks enforcement of payment through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs/attorney fees.

Patient (or Guardian) Signature ____Date:___________