JAMES H. SINKS, D.D.S., APC

PRACTICE LIMITED TO PERIODONTICS, DENTAL IMPLANTS,
REGENERATIVE, AND ESTHETIC PERODONTAL PROCEDURES

PATIENT REGISTRATION

Date: _____

Dr.
Mr.
Ms.
Mrs.
Name: Miss _____ Email: _____

Home Ph.: _____ Office Ph.: _____ Cell Ph.: _____

Home Address: _____ City: _____ State: _____ Zip: _____

How Long at this Address? _____ Birthdate: _____/_____/_____ CA Driver's License #_____

Your Employer: _____ Occupation: _____ Years with firm: _____

Employer's Address: _____ City: _____ Spouse's Name _____

Spouse's Employer: _____ Spouse's Birthdate: _____/_____/_____

Employer's Address: _____ City: _____ Phone: _____

Nearest Relative: _____ Home Phone: _____
Not Living With You

Relative's Address _____ Work Phone: _____

Physician's Name and Address: _____ Phone: _____

Dentist's Name and Address: _____ Phone: _____

Referred By: _____ Address: _____Phone: _____

Who is financially responsible for this bill? _____ Your Social Security No. _____-_____-_____

FOR PATIENTS WITH DENTAL INSURANCE

Insured Person: _____ Social Security No. _____-_____-_____

Subscriber / Insured ID No. _____ Name of Plan: _____

Address: _____ Group No.:_____

Do you have secondary dental insurance coverage? _____ (If yes, please give us the following information)

Spouse's Soc. Sec. No.: _____-_____-_____ Name of Plan: _____ Group No.:_____

Address: _____

If you do not have an insurance form with you please provide us with your insurance card.

I request and consent to treatment as necessary or desirable to the care of the patient first named above, including whatever drugs, medicine, performance of operations and laboratory, x-ray, or other studies that may be used by the attending doctor or his staff or qualified designate. I also certify that the above information is true and correct.

Signed _____
Patient, (parent or agent if under 18)