Felix H Cano, DDS, PA

Springtown & Jacksboro Family Dental

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial** _____

Preferred Name: _____

Responsible Party **If someone other than the patient**

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc Sec: _____ Driver's Lic: _____

◯ Responsible Party is a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Bitrth Date: _____ Age: _____ Soc Sec: _____ Driver's Lic: _____

Email: _____ ❑ I would like to receive correspondences via emial ❑ text

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Pref. Pharmacy: _____

Section 3

EMERGENCY CONTACT: _____

DAYTIME PHONE: _____

REFERRED BY: _____

Primary Insurance Information

Name of Insure: _____ Relationship to Insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem Benefits: _____.00 Rem. Deduct: _____.00

Treatment Authorization

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. Injections may also damage nerves leading to temporary or permanent numbness. The numbness may affect the teeth, jaws, tongue, lips and soft tissues of the mouth. The doctor will do everything possible to minimize this risk. **I authorize the dentist and staff to make routine and necessary consultations with dentist, physicians and pharmacists that may affect my dental treatment. I understand that payment is expected when services are rendered, 1/4% per month (18% per year) will be added on all accounts not paid within 30 days. Please be advised that we do charge a fee for all failed and canceled appointments without a 24 hours notice - (Doctor: $50.00 • Hygienist: $30.00).**

X _____ **Today's date:** _____