ADVANCED DENTAL CARE

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:		Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address: E-Mail address	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose office because/Referred to office by (please check one box):		❑ Postcard	❑ Location	❑ Radio
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Insurance Company:

Please indicate primary insurance			Address	State		❑ Phone	
❑ Medicaid #							

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that my dental insurance may pay less than the actual bill for services. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments in full on all accounts. Should any disagreements arise, I agree to sit down and talk with the doctor about my treatment. If collection of my account requires legal action, I will be responsible for the cost of litigation. I also authorize Advanced Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*