WELCOME
TO ADVANCED DENTAL

Please take a few minutes to answer the following questions so we can better assist you with your health care needs

PATIENT INFORMATION

Date_____

Patient Name_____ Male ☐ Female ☐
(Last Name) (First Name)

Birth date _____/_____/_____ Patient Social Security# _____ - _____ - _____

Address _____ Apartment _____

City _____ State_____ZIP ___ ___ ___ ___ ___

Home Phone: _____	**Cell Phone:** _____	**e-mail:**

Referred by Doctor: _____ **Clinic Name:** _____

Clinic Address: _____

IN CASE OF EMERGENCY CONTACT:

Name _____Relationship _____

EMERGENCY PHONE NUMBER:

PRIMARY INSURANCE

Insurance Company _____

Subscriber _____ Subscriber ID# _____Group:_____
(Last Name) (First Name)

Relation to Patient _____ **Subscriber** Birth date _____/_____/_____**Subscriber** SS#_____

Subscriber Address _____ **Home Phone: ( )**

City _____ State_____ZIP ___ ___ ___ ___ ___

ADDITIONAL INSURANCE

Insurance Company _____

Subscriber _____ Subscriber ID# _____Group:_____

Relation to Patient _____ **Subscriber** Birth date _____/_____/_____**Subscriber** SS#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to office Dr. _____ all insurance benefits, for any services provide me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for relates services. I agree to pay for all charges not covered by a third party payer. I Authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

Signature _____ Date _____