# 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 _____