ADVANCED DENTAL GROUP

PATIENT INFORMATION

DATE: _____

NAME _____ ❑ MARRIED ❑ SINGLE ❑ MALE ❑ FEMALE
(PLEASE PRINT) LAST FIRST M

SOCIAL SECURITY # _____ BIRTHDATE _____

ADDRESS: _____
STREET APT# CITY STATE ZIP

PHONE NUMBERS: _____
HOME CELL WORK

EMAIL (*FOR APPOINTMENT CONFIRMATIONS*):_____

NAME OF EMPLOYER _____ ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ❑ PATIENT ❑ GUARDIAN ❑ SPOUSE ❑ FATHER ❑ I

TO CONFIRM APPOINTMENTS:

❑ PHONE *(circle one)* HOME, CELL, WORK
❑ EMAIL
❑ TEXT MESSAGE

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED

DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
ADDRESS – STREET, CITY, STATE, ZIP	ADDRESS – STREET, CITY, STATE, ZIP
PHONE(S) - HOME, CELL, WORK	PHONE(S) - HOME, CELL, WORK
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE COMPANY	EMPLOYER DENTAL INSURANCE COMPANY
SSN# SUBSCRIBER # GROUP#	SSN# SUBSCRIBER # GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____

PHONE # _____

Has any member of your family ever been treated in our office? ❑ YES ❑ NO

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
❑ YES ❑ NO

Payment is to be made in full at each appointment via
❑ Cash ❑ Personal Check ❑ Credit Card

SERVICE CHARGE

If I do not pay the entire new balance within **60** days of the monthly billing date, a service charge of **Fifty Dollars ($50.00)** will be applied to last month's balance. In the case of a default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party Date