Advanced Dental Health Center

Pampering patients, Brightening smiles

PATIENT INFORMATION

DATE_____________

Patient Name:____Legal Name:______________________

Address:__________________________________ City:_____________________ State:_______ Zip:______

Home Phone:(____)______________ Work Phone:(____)______________ Cell Phone:(____)______________

Email Address:____________________________________ Patient DOB:________________ Sex: ☐ M ☐F

Marital Status : ☐Single ☐Married ☐Divorced ☐Widowed Social Security #:_________________________

☐ Full Time Student / Where?____________________________________ Responsible Party: ☐ Self ☐ Other

Whom may we thank for referring you? ☐ Real Yellow Pages ☐ Yellow Book ☐ Coupon ☐ Letter ☐Website

☐ News Paper/Magazine Ad ☐ Friend/Family Name____________________ ☐ Other__________________

Patient's Employer:______________________________ Drivers License # ______________________________

City:__________________________State:_______ Zip:_________

Spouse's Name:__________________________________ Spouse's Cell #:_____________________________

IN CASE OF AN EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name:____________________________________ Relationship:______________________________________

Home Phone:(____)___________ ______________ Work Phone:(____)_________________________________

DENTAL INSURANCE

Primary Insurance Company:______________________________Subscriber Name:______________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

ID#: _________________________________ Group #:________________ Subscriber's DOB:___________

Subscriber's Employer:_______________________________________

Secondary Insurance Company:____________________________Subscriber Name:______________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

ID#: _________________________________ Group #:________________ Subscriber's DOB:___________

Subscriber's Employer:_______________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____
Name of Insurance Company(ies)
and assign directly to Dr. _________________________________ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____

Signature of Patient, Parent or Guardian   Date

____ ____

Please Print Name of Patient, Parent or Guardian   Relationship to Patient