Welcome _____ Age _____ Date _____

Patient's Name _____ Date of Birth / / **q** Female **q** Male

Last First M. Initial

If Child: Parent's Name: _____

q Single **q** Married **q** Divorced **q** Widowed **q** Minor

Residence – Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res: _____ Bus: _____

Cell Phone: _____

q *I understand this will be used for text message appt confirmation* _____*Initials*

Email: _____

q *I understand this will be used for appt confirmation* _____*Initials*

Preferred Method of Appointment Confirmation ***q*** *Email* ***q*** *Text* ***q*** *Phone*

Patient/Parent Employed by: _____

Present Position: _____

How long held: _____

Spouse/Parent Name _____

Spouse Employed By: _____

How long held: _____

Who is responsible for account _____

Drivers License No. _____

Method of Payment:

Insurance **q** Cash/Check **q** Credit Card **q** Care Credit **q**

Purpose of Visit _____

Other Family Members in this Practice: _____

_____

Whom may we thank for this referral? _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency: _____

_____

_____

Dental Insurance 1st Coverage

Employee Name: _____ Date of Birth: _____

Employer Name: _____ Years: _____

Name of Insurance Co: _____

Address: _____

_____

Telephone No. _____

Program or policy # _____

Social Security No. _____

Dental Insurance 2nd Coverage

Employee Name: _____ Date of Birth: _____

Employer Name: _____ Years: _____

Name of Insurance Co: _____

Address: _____

_____

Telephone No. _____

Program or policy # _____

Social Security No. _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following personas who are involved in my care (or my child's care) or payment for that care.

_____

Signature **Date**

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

_____

Signature **Date**

Patient Information Form

Advanced Dental Care
Gentle modern care for your health and smile