Advanced Family Dentistry Registration Form

Patient Information **Today's Date:**

Name: _____ Nickname: _____
Address: _____ SS#: _____
City_____State_____Zip_____ Home phone: _____
Gender: Male/Female Married/Single Cell Phone: _____
Birthdate: _____ Email: _____
Employer: _____ Employer phone#: _____
Insurance company: _____ Insurance Co. ID#: _____
Emergency contact: _____ Referred by: _____
Emergency contact phone number#:

Responsible Party Information (if different than above....Otherwise skip)

Name: _____ Birthdate: _____
Address: _____ SS#: _____
City_____State_____Zip_____ Gender: Male/ Female Married/ Single
Home Phone: _____ Email: _____
Cell Phone: _____ Insurance Company: _____
Employer & Phone#: Insurance ID#:

Authorization of Insurance payment:

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 information on this page.

PATIENT OR GUARDIAN SIGNATURE: **DATE:**

Acknowledgement of receipt of notice of Privacy Practices:

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. My consent to disclosure of records shall be effective until I revoke it in writing. I acknowledge that I have received a copy of Advanced Family Dentistry's Notice of Privacy Practices. This notice describes how Advanced Family Dentistry may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

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

PATIENT OR GUARDIAN SIGNATURE: **DATE:**