ADVANCED FAMILY DENTAL CARE

Patient Information

(Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____ Cell Phone _____

If Student, Name of School/College _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How You Found Us? ☐ Google Search ☐ Email from us ☐ Post Card ☐ Our Sign ☐ Insurance ☐ Yelp ☐ Septa Ad

☐ Patient Referral (Name:_____) ☐ One of our Staff ☐ Other _____

Person to Contact in Case of Emergency _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Additional Dental Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Medical Insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Pharmacy Name _____ Pharmacy Phone _____

Payment In Full at Each Appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ Debit Card

Responsible Party

Person Financially Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Authorization and Release

Payment is due in full at time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.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 release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that i may need during diagnosis and treatment, with my informed consent.

X_____ _____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date | Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient