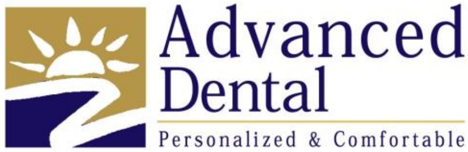

# Patient Registration

Welcome and thank you for selecting our office to serve your dental needs! We're committed to offering our patients the finest and most comprehensive/complete dental care available today. In order to allow us to best meet your needs, please fill out the information carefully.

Name: ______________________________________________ Date of Birth: ___________________________

Nickname: ___________________________________________ Social Security #: _________________________

Address: ____________________________________________

City, State, Zip: ______________________________________

Home Phone #: _______________________________________

Work Phone #: _______________________________________

Gender
( ) Male
( ) Female

Marital Status
( ) Single
( ) Married
( ) Divorced
( ) Widowed

Cell Phone #: ________________________________________ Employer: ______________________________

Email Address: _______________________________________ Occupation: ____________________________

What is your preferred method of contact? ( ) PHONE ( ) TEXT ( ) EMAIL *check all that apply*
What is the best time of day to reach you? ( ) MORNINGS ( ) AFTERNOONS ( ) EVENINGS after _____ P.M.
Where do you prefer to receive calls? ( ) HOME ( ) WORK ( ) CELL *check all that apply*
Do you have a fixed or flexible work schedule? ( ) FIXED ( ) FLEXIBLE
If we have an opportunity to see you sooner than your reserved time, would you like us to let you know? ( ) YES ( ) NO

**Who may we thank for referring you to our office, or how did you hear about us?** ______________________________
***We appreciate & welcome new patients; in fact, we will place a **$50 credit** on your account to use toward dental treatment/procedures for EACH friend, co-worker, family member whom you refer & becomes a new patient in our office!*** ***Ask us about our Care2Share Program for full detail***

Emergency Contact Name & Phone #: __________________________________________________________

## Dental Insurance Information

Policy Holder Name: ______________________________ Date of Birth: __________________________

Employer: _______________________________________ Insurance Co: __________________________

Claims Address: __________________________________ SS/ID #: ______________________________

Relation to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other Group #: _____________________________

***Please provide a copy of your medical insurance card, as well as your dental card, as some dental services may be billable under your medical plan***

## Responsible Financial Party

Name: _________________________________________ Relationship to Patient: ___________________

Social Security #: ________________________________ Date of Birth: __________________________

Driver's License #: _______________________________ State of Issue: __________________________

*I consent and authorize Advanced Dental to take face, profile, head/neck &/or inside the mouth photographs, video or any other image that may be necessary of me/my child, with or without my given name or with a fictitious name, for treatment, education and any other lawful healthcare purpose. I release and forever discharge these photos from any claim of ownership, demands or liability on account for such use and acknowledge they are the exclusive property and copyright of Advanced Dental.*

**Signature:** _____________________________________ **Date:** ______________________________

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S M I L E D E S I G N E R