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Advanced Dental Professionals

**Patient Information**

Name _____
SS/HIC/Patient ID# _____Home Phone (___)_____ Cell Phone (___)_____
Address _____ E-mail _____
City _____ State _____ Zip_____ Sex Male Female Age ____ Birth date_____
Patient Employer/School_____ Occupation _____
Employer/School Phone (___)_____ Employer/School Address (___)_____
Whom may we thank for referring you? _____
In case of an emergency, who should be notified? _____

**Primary Insurance**

Person Responsible for Account _____Phone (___)_____
Relation to Patient _____ Birth date _____ Soc. Sec. #_____
Address (if different from patient's) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____Group # _____ Subscriber #_____
Names of other dependents covered under this plan _____

**Authorization**

I certify that I, and/or my dependent(s), have insurance coverage with the Insurance Company(ies) named above on this form and assign directly to Advance Dental Professionals all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

I understand the dentists of Advance Dental Professionals may use my health care information and may disclose such information to the insurance mentioned earlier company(ies) and their agents to obtain payment for services and determine insurance benefits or the benefits payable for related services

If I have dental insurance, this office will file my insurance claim for me. An initial pre-treatment estimate of costs may be submitted by the office to my insurance carriers, after my examination, and before treatment starts. The office may require pre-payment of all or a portion of anticipated charges before the start of service.

My account balance will be given 60 days of free handling, usually to await insurance handling. FULL PAYMENT OF THE ENTIRE BALANCE IS EXPECTED 60 DAYS FROM DATE OF TREATMENT. After 60 days 1.5%-month handling applied to all unpaid balances. The office offers several financial payment options for your convivence. You can obtain more information about these alternatives from the office's front desk.

By signing below, I certify that I have read and understood the above information to the best of my knowledge, and that the above questions have been arcuately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Name (Print) _____
Patient (Guardian) Signature_____ Date _____
Office Initials _____