Advanced Family Dentistry
Patient Registration

Patient Information

Patient's First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address: _____City: _____ State: _____ Zip Code: _____

Patient's Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security: _____/_____/_____ Driver's License: _____

Please share your **preferred** contact method: (Check one or indicate order of preference by number with #1 being highest priority)

Email:		Home Phone:	
Work Phone:		Cellular Phone: Call / Text (Please select method)	

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

Referral Source: Patient/Signage/ Online (Internet)/ Dentist (another office)/ Other: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Is Patient the ☐ Insurance Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)

Patients Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Responsible Party's First Name: _____ Last Name: _____ Middle Initial: _____

Responsible Party's Street Address: _____City: _____ State: _____ Zip Code: _____

Phone Number: _____ Driver's License # _____ Social Security Number: _____/____/_____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth: _____ Social Security Number: _____/____/_____ Employer: _____

Information found on Dental Insurance Card Group Number: _____ Payer ID: _____

Insured SSN or Member ID number: _____ Insurance Company: _____ Phone:_____

Insurance Company: _____
(Claims Address) Street Address City State Zip

Secondary Insurance Information

Name of Insured: _____ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth: _____ Insured Social Security Number: _____/____/_____ Employer: _____

Information found on Dental Insurance Card Group Number: _____ Payer ID: _____

Insured SSN or Member ID number: _____ Insurance Company: _____ Phone: _____

Insurance Company: _____
(Claims Address) Street Address City State Zip

Advanced Family Dentistry
Written Acknowledgment for Notice of Privacy Practices, General Treatment Consent and Financial Policy

I hereby acknowledge that I have received the Notice of Privacy Practices, the General Treatment Consent, and Financial Policy for Advanced Family Dentistry (AFD). I understand that I may request a copy from AFD at any time and that a copy is located on the practice website and prominently displayed in the office.

I hereby acknowledge that I have read and understand the Financial Policy and General Treatment Consent.
I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.
I acknowledge that all my questions were answered to my full understanding and satisfaction.
I acknowledge that I understand my financial obligation.

_____
Signature of Patient or Legal Representative Date

FOR FAMILIES: PLEASE LIST ALL FAMILY MEMBERS UNDER THE AGE OF 18

Name (First, Last MI)	DOB	Name (First, Last MI)	DOB
Name (First, Last MI)	DOB	Name (First, Last MI)	DOB
Name (First, Last MI)	DOB	Name (First, Last MI)	DOB

AFD USE ONLY

Description of Legal Representative (Attach necessary documentation):

_____

Documentation of Good Faith Attempt to get acknowledgment signature

- ☐ Document present to patient, patient refused to sign
- ☐ Emergency situation not able to present NPP of obtain signature
- ☐ Documentation presented unable to obtain signature due to communication failures
- ☐ Documentation mailed to patient, not returned to Advanced Family Dentistry

Advanced Family Dentistry
Authorization

I hereby give my consent for Advanced Family Dentistry to use and disclose protected health information (PHI) for reasons other than treatment, payment, and healthcare operations (TPO). I understand this authorization shall be enforce until revoked. I may revoke this consent in **writing**, except to the extent that AFD has already taken action in reliance to my prior consent. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____
Signature of Patient or Legal Representative Date

_____
Printed Name of Legal Representative, if applicable

_____
Witness Date

FOR FAMILIES: PLEASE LIST ALL FAMILY MEMBERS UNDER THE AGE OF 18

Name (First, Last MI) DOB	Name (First, Last MI) DOB
Name (First, Last MI) DOB	Name (First, Last MI) DOB
Name (First, Last MI) DOB	Name (First, Last MI) DOB

I give authorization to disclose the marked information to those indicated below:

Description of Legal Representative (Attach necessary documentation):

Receiving Entity/Person: Please fill out boxes for those entities or persons you wish to get the described information about you.	**Description of information to be given to said Entity or Person**
Name:	( ) Appointment time
Relationship:	( ) Financial Information
Contact Information:	( ) Clinical Information
Name:	( ) Appointment time
Relationship:	( ) Financial Information
Contact Information:	( ) Clinical Information
Name:	( ) Appointment time
Relationship:	( ) Financial Information
Contact Information:	( ) Clinical Information
Name:	( ) Appointment time
Relationship:	( ) Financial Information
Contact Information	( ) Clinical Information
Name:	( ) Appointment time
Relationship:	( ) Financial Information
Contact Information	( ) Clinical Information

AFD Office Use Only: Receiving Employee _____ Date Received: _____