Advanced Family Dentistry of Cape Cod

PATIENT REGISTRATION

Patient Information

First Name: ___________________________ Last Name: _____________________________ M.I. ____
Pref Name: ___________________________ Sex: ○ Male ○ Female Birth Date: __________________
Responsible Party (If patient is under 18): _______________________________
Mailing Address: ____
City, State, Zip: ________________________________ Home Phone: __________________________
Cell Phone: ____________________________ Email Address: _________________________________
Marital Status: ○ Married ○ Single ○Widowed ○Divorced ○ Life Partner
Emergency Contact: _____________________ Relationship: _________________ Phone: ___________
How were you referred to our office? ____________________________________

Insurance Information

Please provide copies of Insurance cards to the front desk

DENTAL INSURANCE

Name of Insured: _________________________ Insured Birth Date: _____________________________
Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other
Insurance Company: _____________________________ ID# __________________________________

MEDICAL INSURANCE (For Snoring & Sleep Apnea Patients Only)

Primary Insurance
Name of Insured: _________________________ Insured Birth Date: _____________________________
Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other
Insurance Company: _____________________________

Secondary Insurance (If Applicable)
Name of Insured: _________________________ Insured Birth Date: _____________________________
Relationship to Insured ○ Self ○ Spouse ○ Child ○ Other
Insurance Company: _____________________________ ID#__________________________________

Medical Contacts

Primary Care Physician: ______________________________ENT:________________________________
Dentist: ______________________________ Other MD: ____________________________

I certify this information is true, accurate, and complete to the best of my knowledge:
Signature: _________________________________ Date: _____________________________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I agree to allow Advanced Family Dentistry of Cape Cod to transfer appropriate medical, administrative and financial information to insurance companies, billing clearing houses as well as any referral doctors for purposes of treatment or consultation. I have been informed that the Privacy Policy Notice for Advanced Family Dentistry of Cape Cod is available for my review at any time.

Patient’s Signature: ___________________________ Date:_________________________
For (if patient is under 18): __________________________________