ADVANCED ORTHODONTICS

Adult Registration Form

N64 W24050 Main Street, Suite 200
Sussex, WI 53089
(262) 820-0825

Date:_____

Patient's Last Name:_____First Name:_____Nickname:_____

Patient's Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ E-mail:_____

Patient's Birth Date:_____ Sex: M F S.S.N.:_____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Your Employer: _____ Work Phone:_____

Family Dentist:_____ Physician:_____

Who may we thank for referring you to our office?_____

Financially Responsible Party
or Spouse's Name:_____ Birth Date:_____ S.S.N.#_____

Employer:_____ Work Phone #:_____

Cell Phone #:_____ Email:_____

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Policy Holder:	Policy Holder:
Insurance Company:	Insurance Company:
Address:	Address:
Phone #:	Phone #:
Subscriber#:	Subscriber #:
Group #:	Group #:

I authorize *Advanced Orthodontics* to perform diagnostic procedures and treatment as necessary for proper dental care. I am aware that diagnostic procedures may incur a fee that is separate from the orthodontic treatment fee.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

I authorize release of any information concerning my heath care, advice and treatment to another dentist.

I wish to assign benefits to *Advanced Orthodontics* and am responsible for all co-payments and deductibles. I understand I am financially responsible for payments in full on the account. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for services not paid, in whole or part by my dental care payer.

Patient Signature:_____ Date:_____