ADVANCED ORTHODONTICS

Registration Form

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

Date:_____

Patient's Last Name:____ _____First Name:_____Middle Initial:_____
Date of Birth: _____ Age: _____ Nickname: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Family E-mail: _____
Other family members treated in our office: _____
Dentist: _____ Physician: _____
Who may we thank for referring you to our office: _____

Father's Name: _____ Birth Date: _____ S.S.N.# _____
_____ Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Guardian

Address: _____
Employer: _____ Cell Phone #:_____

Mother's Name: _____ Birth Date: _____ S.S.N.#_____
_____ Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Guardian

Address: _____
Employer: _____ Cell Phone#:_____

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 child's 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 child's 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.

Responsible Party's Signature:_____ Date:_____