WELCOME TO ADVANCE BLVD DENTAL HEALTH GROUP

PATIENT REGISTRATION

TITLE: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐

NAME: _____ HOME PHONE: _____
Last First Initial

WORK PHONE: _____

CELL PHONE: _____ _____

ADDRESS: _____
Street City Postal Code

DATE OF BIRTH: _____ AGE: _____ email _____
mm dd yy

EMPLOYER: _____ YEARS EMPLOYED: _____

SPOUSE / PARENT / GUARDIAN: _____ DATE OF BIRTH: _____
mm dd yy

EMPLOYER: _____ YEARS EMPLOYED: _____

IN CASE OF EMERGENCY: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

NAME OF PRIMARY DENTAL INSURANCE COMPANY: _____

POLICY NUMBER: _____

NAME OF OTHER DENTAL INSURANCE COMPANY: _____

POLICY NUMBER: _____

COVERAGE: _____
(For Office Use Only)

INFORMED CONSENT / GENERAL RELEASE

1. I, the undersigned, certify that all the information I have or will complete is/will be correct and without any known omission.
2. I consent to the release of medical and/or dental information from my physician, previous dentists or other health care providers as required by this dental office.
3. I authorize this dental office to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetics, premedication and radiographs (x-rays) as deemed necessary or advisable and I assume all responsibility for payment of fees associated with those procedures.
4. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents.
5. I give permission for the release of information contained in insurance claims to be submitted electronically, direct via computer (if possible)and assign benefits to Dr. Ursula Flis, Dr. Rista Urukalo, Dr. Steven Sloboda and authorize payments directly to them.

Signature: _____ Date: _____