ADVENTURE
DENTAL • VISION
ORTHODONTICS

CONFIDENTIAL

We are happy to welcome you to our office!
Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date____________________________________

Patient's last name______________________ First name____________________ Middle initial______

Prefers to be called______________________ Date of Birth ______________ Sex O Male O Female

Social Security# ________________________ School_________________________________

Email address(es) ____

Home address ___________________________ City, State, Zip code_______________________

Home phone (   ) ______________________ Cell phone (   ) ________________________

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s)____

Patient lives with (check all that apply) O Mother O Father O Stepmother O Stepfather O Grandparent(s)

O Other____

Primary Guardian Full Name_______________________________________Date of Birth____________

Occupation______________________________ Email address_____________________________

Address (if different)____

Home Ph. (   )_______________ Cell Ph. (   )________________ Work Ph. (   )______________

Secondary Guardian Full Name_____________________________________Date of Birth____________

Occupation______________________________ Email address_____________________________

Address (if different)____

Home Ph. (   )_______________ Cell Ph. (   )________________ Work Ph. (   )______________

Financial Responsibility

Who is financially responsible for this account?______________________________________

Address____

City _____________________________ State_______________________ Zip code____________

Home phone (   )_________________________ Cell phone (   ) __________________________

Email address(es)____

Social Security #__________________________ Employer____________________________________

Who will be responsible for bringing the patient to appointments? _____________________________

Dental / Orthodontic Insurance

Prima... ...der's full name___________________________________ D...

Social... ______________ Relationship to patient_____________________

Address and p... ...e)

Employer______________________________ Addr...

Insurance company ______________ ... ___________ ID#______________

Does this policy have orthodontic ben... ...n't Know

Secondary policy holder's full nam... _____________ Date of Birth_____________

Social Security #______________________ Rela...

Address and phon...

Employer_______________________________ Address__________________________

Insu... ______________________________ Group #___________________________

Does this policy have orthodontic benefits? O Yes O No O Don't Know

Medical / Vision Insurance

Primary policy holder's full name____________________ Date of Birth__________

Social Security #____________________ Relationship to patient____________________

Address and phone (if not listed on front.)______________________________

Employer____________________ Address____________________

Insurance company ____________________ Policy #_______________ ID#_______________

Secondary policy holder's full name____________________ Date of Birth__________

Social Security #____________________ Relationship to patient____________________

Address and phone (if not listed on front.)______________________________

Employer____________________ Address____________________

Insurance company ____________________ Policy #_______________ ID#_______________

Physician

Patient Phy____________________ City, State____________________

Last seen__________ Reason__________ appointment__________

Most recent physical exam______________________________

Other physicians/health care providers b

Name____________________

Reason______________________________

Name____________________ City, State____________________

Reason______________________________

Notice of Privacy

Acknowledgment of Receipt of Notice of Privacy Practices Posted. Copies available upon request.

I have read over this office's Notice of Privacy Practices records and materials.

X ____________________ ____________________

Patient/Guardian Signature Date

----------------------------- For Office Use Only -----------------------------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

( ) Individual refused to sign ( ) Communication barriers prohibited obtaining acknowledgment.

( ) An emergency situation prevented us from obtaining acknowledgment. ( ) Other (Specify) ____________________

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Authorization

I authorize the Provider to release any information including the diagnosis and records of treatment or examination rendered to the patient during the period of such are to third party payers and/or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to the Provider or Provider's group those insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I authorized the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X ____________________ _

Patient/Guardian Printed Name

X ____________________ ____________________

Patient/Guardian Signature Date