ADVANCED
DENTISTRY OF CORAL SPRINGS

PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____ **Date:** _____
Last First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Divorced ☐ Child ☐ Other _____

Social Security #: _____-_____-_____ **Medicaid ID:** _____ **Birth Date:** _____

Driver's License #: _____ **Office Use Only: Copy in File? ☐ Yes ☐ No

****HIPAA**:** *Do we have your permission to leave appointment, billing or dental information on your answering machine, voicemail or email at the following? Please check "Yes" or "No" for each contact number.*

Telephone Numbers

Home: _____	☐ Yes ☐ No	Best time to call: _____
Work: _____ Ext: _____	☐ Yes ☐ No	Best time to call: _____
Cell Phone: _____	☐ Yes ☐ No	Best time to call: _____
Text Message: _____	☐ Yes ☐ No	
E-mail: _____	☐ Yes ☐ No	
Pager: _____	☐ Yes ☐ No	
Fax: _____	☐ Yes ☐ No	

DO YOU NEED COMMUNICATION ASSISTANCE? ☐ Yes, please explain: _____
☐ No (No communication assistance needed)

Employer: _____ **Occupation:** _____

Employer's Address: _____
Street City State Zip Code Telephone

In case of an emergency, contact: _____ **Phone:** _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Only if the person responsible for this account is NOT the patient, complete the following information for the Guarantor:

Guarantor's Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Single ☐ Married ☐ Divorced ☐ Child ☐ Other _____

Address: _____
Street City State Zip Code

Social Security #: _____-_____-_____ **Birth Date:** _____

Driver's License #: _____ **Office Use Only: Copy in File? ☐ Yes ☐ No

Telephone Numbers: Home: _____ Work: _____ Ext: _____
Cell Phone: _____ Pager: _____ Fax: _____

Employer Name: _____ **Occupation:** _____

Employer's Address: _____
Street City State Zip Code