Aquidneck Dental, Inc. 21 King Charles Drive Portsmouth, RI 02871 401.683.5990

Patient Registration

Please complete each question, signature required at X's

Patient Information Date___/___/___

Patient's Name_____
Last First Middle Preferred

Address_____
Street City State Zip

Home Phone #_(___)_____ **Cell #**(___)_____ OK to receive Text?___ **Email**_____

Date of Birth___/___/___ **Social Security #**_____ **OR Drivers Lic #**_____ **State**____

*If patient is a minor, Parents' or Guardians' name_____

Employer_____ **Work Phone #**__(___)_____ **Ext.**_____

May we call you at work? ☐ **Yes** ☐ **No** **Best time to call**_____ **Best Tel # to call**_____

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

Responsible Party Information

Name of Person Financially Responsible for Account_____
Last First Middle

Responsible Party's Address_____
Street City State Zip

Responsible Party's Home Phone #___(___)_____ Work Phone #___(___)_____

Responsible Party's Social Security #_____ Date of Birth___/___/___ Relation to Patient_____

Responsible Party's Employer_____

Insurance Information

Name of Insurance Cardholder_____ **Cardholder's Date of Birth**__/___/____

Dental Insurance Co._____ Insurance Cardholder's Employer_____ Insured's ID #_____

*Do you have more than 1 dental insurance coverage? ☐ Yes ☐ No (If yes, please complete below)

Name of Secondary Insurance Cardholder _____

Dental Insurance Co._____ Insurance Cardholder's Employer_____ Insured's ID #_____

Consent to Release of Information to Insurance Co. /Consent to Assignment of Benefits

X **Signature** (Parent's signature if patient is a minor)_____

Consent to Aquidneck Dental Associate's Financial & Appointment Policy

In an effort to hold down fees, payment is required at the time of service. If you have dental insurance, we will estimate your dental benefit and require payment of deductibles and estimated patient portion when treatment is rendered. Please remember that we try to help you understand and to maximize your insurance benefits, but dental insurance is a contract between the patient, the employer and the insurance company. Ultimately, the patient is financially responsible for all treatment rendered.

As a courtesy, Aquidneck Dental Associates requires 48 hours notice for any appointment change or cancellation to avoid an office visit fee.

X **Signature** (Parent's signature if patient is a minor)_____

Revised 02/01/11mc

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