Advanced Dentistry of Richmond
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Patient Information:

Name_____ Date of Birth_____ SSN_____-____-_____

Male____ Female_____Other_____ Single____ Married_____ DP_____Widowed_____

Address_____ City_____ State_____Zip_____

Email_____Preferred Phone#_____ Alternate #_____

Current or former occupation_____Employer_____

Responsible Party (__) same as patient or _____Relation_____

Referred By: Dr._____Patient or Family member_____ Online_____

Emergency Contact_____ Phone #_____

DENTAL INSURANCE INFORMATION

Primary	***Secondary***
Ins. Company	Ins. Company
Subscriber	Subscriber
Date of Birth	Date of Birth
SSN	SSN
Relation to patient	Relation to patient
Insurance ID #	Insurance ID #

I am responsible for payment of services when services are rendered unless prior arrangements have been approved. As a courtesy, ADoR will file insurance claims for our patients, however our office does not participate with any insurance plan. I agree that my insurance is a contract between myself and the insurance company and ADoR is not a party to that contract. I am responsible for any unpaid balance and non-covered services. If for any reason, my account is sent to a collection agency, I agree to pay all cost associated with such collections (+42% of the balance) and attorney /court fees, if necessary. ADoR reserves the right to charge interest at 1.5% per months (18% APR) on any account unpaid after 30 days. I am responsible for informing the office of any changes to my information/insurance prior to my appointments. I agree to pay ***$50 return check fee***, if necessary. I give my permission for ADoR to release information to my insurance company, its agents or third party processors as necessary to obtain payment.

If, due to overpayment, my account should have a credit balance, I request the following:

_____Keep on account for future treatment **OR** _____ send me a check for my credit balance

I agree to provide a minimum of 48 BUSINESS hours' notice to cancel or reschedule any appointment. When insufficient notice is given, AdoR reserves the right to charge $150 per scheduled hour.

To the best of my knowledge, all information provided is true and correct. This information will be kept in strictest confidence. The above constitutes conditions of treatment and I agree to abide by these conditions.

Patient/Parent/Guardian____ Date_______________________