Today's Date:_______________

Adult Registration Form

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

Patient's Legal Name:______________________________ (Last / First) Preferred Name:______________ Male ☐ Female ☐

Birth date:____/____/________ Age:______ SS#:_______-_____-________ Email:______________________________

Address:____________________________ City:__________________ State:____________ Zip Code:____________

Home Phone(_____)_____-_________ Cell Phone(_____)_____-_________

Appointments should be confirmed by ☐ Text Cell ☐ Call Cell ☐ Call Home

NEW PATIENTS

Previous/Current Dentist:________________________________ Last Visit Date:__________________

How did you hear about us?____

Other Family Members Seen by Us:__________________ __________________ __________________

SPOUSE

Legal Name:______________________________ (Last / First) Birth date: _____/_____/________ SS#:______-_____-________

Cell Phone:(____)_______-__________ Employer:____________________________ Wk#(______)_______-_________

DENTAL INSURANCE (PRIMARY)

Insured's Name:______________________________ Relation:______________ Insured's DOB:_____/_____/________

SS#:________-_______-____________ Insured's Employer:____

Insurancy Company:__________________________ ID:____________________ Group#____________________

Insurance Company Address:____ City:____________________

State:______________ Zip Code:________________ Phone # (______)_______-____________

DENTAL INSURANCE (SECONDARY)

Insured's Name:______________________________ Relation:______________ Insured's DOB:_____/_____/________

SS#:________-_______-____________ Insured's Employer:____

Insurancy Company:__________________________ ID:____________________ Group#____________________

Insurance Company Address:____ City:____________________

State:______________ Zip Code:________________ Phone # (______)_______-____________

CONTACT IN CASE OF EMERGENCY

Name:________________________________ Relation: _______________ Phone # (_____)_________-___________

The following persons are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name:______________________ Relation_____________ Name:______________________ Relation_____________

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time service is rendered.

Patient Signature:____ Date:__________________