

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: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Male  Female   
Last First

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: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Last First

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: \_\_\_\_\_