Adult Registration Form

Patient Information

First Name: _____ Last Name: _____ Middle Initial:_____

Birth Date: _____ Soc Sec: _____ Nick Name: _____

Sex: Male____ Female ____ Marital Status: Child____ Single____ Married____ Divorced____ Other____

Address: _____City, State, Zip:_____

Cell Phone: _____ Home Phone: _____

Text and email is for appointment reminders, oral health promotion, dental record information and reminders of uncompleted treatment

Would you like to be contacted via text? Yes_____ No_____ Would You like to be contacted via email? Yes_____ No_____

Email Address: _____

Emergency Contact Name: _____ Emergency Contact #: _____

How did you hear about us? Google___ Yelp___ Facebook___ Friend/Relative _____Other _____
(Check all that apply)

Responsible Party (if patient has a guardian)

First Name:_____ Last Name:_____ Middle Initial:_____

Birth Date: _____ Soc Sec: _____

Sex: Male____ Female ____ Marital Status: Child____ Single____ Married____ Divorced____ Other____

Address: _____City, State, Zip: _____

Cell Phone: _____ Home Phone: _____

Text and email is for appointment reminders, oral health promotion, dental record information and reminders of uncompleted treatment.

Would you like to be contacted via text? Yes_____ No_____ Would You like to be contacted via email? Yes_____ No_____

Email Address: _____

Primary Insurance

Dental Insurance Name: _____ Phone #: _____

Insurance Holder Name: _____ Date of Birth: _____

Insurance Member SS #: _____ Group #: _____

Secondary Insurance

Dental Insurance Name: _____ Phone #: _____

Insurance Holder Name: _____ Date of Birth: _____

Insurance Member SS #: _____ Group #:_____

To the best of my knowledge, the information on this is accurate and current. It is my responsibility to inform the dental office of any changes in my information.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____DATE: _____