# Adult Registration Form

## Patient Information

First Name: ________________________________ Last Name: ___________________________________ Middle Initial:_____

Birth Date: ___________________________ Soc Sec: _______________________________ Nick Name: __________________

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

Address: ______________________________________________City, State, Zip:_____________________________________

Cell Phone: _____________________________________ Home Phone: __________________________________

**Text and email is for dental record information, appointment reminders and other requested electronic communication.**

Consent to communicate via text? Yes_____ No_____ Consent to communicate 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 (only if patient has a legal guardian/power of attorney)

First Name:________________________________ Last Name:___________________________________ Middle Initial:______

Birth Date: ___________________________ Soc Sec: __________________________________

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

Address: ___________________________________________City, State, Zip: ________________________________________

Cell Phone: _____________________________________ Home Phone: __________________________________

**Text and email is for dental record information, appointment reminders and other requested electronic communication.**

Consent to communicate via text? Yes_____ No_____ Consent to communicate 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/GUARDIAN:** ________________________________________**DATE:** ________________________