

ADULT REGISTRATION FORM

Today's Date _____

First Name _____ Last _____ Middle initial _____

Date of birth _____ Gender male female SS# _____

Address _____

Zip _____

Home Phone _____ Cell Phone _____

Marital Status _____ Spouse Name _____

Employed by _____ Work Phone _____

Spouse's Employer _____ Work Phone _____

Primary Dental Insurance carrier _____ ID # _____

Secondary Dental Insurance carrier _____ ID # _____

Responsible Party (if other than above) _____

Family members _____

Nearest Relative to contact (not spouse) _____

Home phone _____ Work Phone _____

Whom may we thank for referring you to our office?

Federal law, effective April 14, 2003, requires this practice to provide each of its patients with the Practice's *Notice of Privacy Policy*. Please read it carefully. We will ask you to sign an *Acknowledgement* of receipt of the *Notice* for our records.

You are responsible for contacting your previous dental provider and authorizing the transfer of your dental records to this office. Please let us know if we can be of assistance.

Did you receive a copy of the office and payment policy? Yes No

By your signature below, you attest that you will be ultimately responsible for any fees for services provided.

Signature _____