# ADULT REGISTRATION FORM

(Please Print)

| Today's date: | Name of general dentist: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ☐Mr. ☐Mrs. | ☐Miss ☐Ms. | Birth date: / / | Age: | Sex: M☐ F☐ |
|---|---|---|---|---|---|---|---|

| Social security no.: | Home phone no.: ( ) | Cell phone no.: ( ) | Email address: |
|---|---|---|---|

| Street address: | City: | State: | ZIP Code: | Yrs/Mo at address: |
|---|---|---|---|---|

| Occupation: | Employer | Yrs/Mo employed: | Employer phone no.: ( ) | Marital Status (please circle one) Single / Mar / Div /Sep / Widow |
|---|---|---|---|---|

| Chose office because/referred by (please check one box): | ☐ Dentist. | (name) | |
|---|---|---|---|
| ☐ Family | ☐ Close to home/work | ☐ Yellow Pages | ☐ Other |
| Other family members seen here: | (name) | ☐ Friend | (name) |

## DENTAL INSURANCE INFORMATION

(Please give insurance card to receptionist)

| Primary subscribers last name: | First name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: Spouse☐ Child☐ Other☐ Self☐ | Insurance co. name: |
|---|---|

| Secondary subscribers last name: | First name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: |
|---|---|---|---|---|---|

| Patient's relationship to subscriber: Spouse☐ Child☐ Other☐ Self☐ | Insurance co. name: |
|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Cell phone no.: |
|---|---|---|---|
| | | ( ) | ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Charles J Ruff, DMD. I understand that I am financially responsible for any balance. I also authorize Charles J Ruff, DMD or insurance company to release any information required to process my claims. I understand that where appropriate, credit bureau reports may be obtained and I can receive a copy of Dr. Ruff's privacy policy and regulations at any time.

| *Patient/Guardian signature* | *Date* |
|---|---|

*I give permission for my photos to be used on Dr. Charles Ruff's social media pages.* ___ *Patient or Parent/Guardian Initials*

Revised 9/2013