DENTAL ASSOCIATES

Date: _____/_____/_____ *e-mail:* _____

Patient: _____

Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Home Ph: (_____) _____ *Cell Ph:* (_____) _____ *Work Ph:* (_____)_____

Birth Date: _____/_____/_____ *Social Security #:* _____

Employer: _____ *Position:* _____

Business Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Spouse's Name: _____

Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Birth Date: _____/_____/_____ *Social Security #:* _____

Daytime Ph: (_____) _____ *Cell Ph:* (_____) _____ *Work Ph:* (_____)_____

Employer: _____ *Position:* _____

Business Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Person Responsible for the Account: _____

Birth Date: _____/_____/_____ *Social Security #:* _____

Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Daytime Phone: (_____) _____ *Work Phone:* (_____) _____

Employer: _____ *Position:* _____

Business Address: _____ *City:* _____ *St:* _____ *Zip:* _____

Primary Dental Insurance Co: _____

Employee: _____ *Group Name:* _____

Group #: _____ *Union/Local #:* _____

Secondary Dental Insurance Co: _____

Employee: _____ *Group Name:* _____

Group #: _____ *Union/Local #:* _____

Who May We Thank for Referring You?: _____

I authorize the release of any information regarding dental treatment. I understand that I am responsible for all fees incurred. I authorize insurance payment to be paid directly to Dental Associates.

Signature: _____ **Date:** _____

ADULT REGISTRATION