ADULT REGISTRATION

First Name:_____**Last Name:**_____

I like to be called:_____

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

Home phone #( )_____ **Work phone#( )**_____ **Ext:**_____

Cellular phone #( )_____

Sex: Male ____ Female ____ **Marital Status:** Married____ Single____ Divorced____ Separated____ Widowed____

Birth Date:_____ **Soc. Sec. #**_____ **Drivers Lic.#**_____

Employer:_____ **Postition:**_____

Employer Address:_____ **City:**_____ **Zip:**_____

SPOUSE INFORMATION (if applicable)

Name:_____

Birth Date:_____ **Soc. Sec.#**_____

Employer:_____ **Work phone#( )**_____ **Ext:**_____

Employer Address:_____ **City:**_____ **Zip:**_____

PERSON TO CALL IF UNABLE TO REACH YOU

Name:_____ **Phone #**_____ **Relation**_____

PRIMARY *DENTAL* INSURANCE INFORMATION (if applicable)

Name of Insured:_____ **D.O.B.:**_____ **ID #**_____

Insurance Company:_____ **Employer:**_____ **Group #**_____

SECONDARY *DENTAL* INSURANCE INFORMATION (if applicable)

Name of Insured:_____ **D.O.B.:**_____ **ID#**_____

Insurance Company:_____ **Employer:**_____**Group #**_____

WHO IS RESPONSIBLE FOR PATIENT'S DENTAL EXPENSES?

Self__ Spouse__ Parent__ Other__

How did you hear about our office?_____

How would you rate your smile?

worst **0 1 2 3 4 5 6 7 8 9 10** best

Do you wish your teeth were straighter?

yes maybe no

Pharmacy Name and Phone #:_____