

Charles J Ruff, DMD ADULT REGISTRATION FORM

(Please Print)

Today's date: _____ Name of general dentist: _____

PATIENT INFORMATION

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

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

Work phone no.: _____

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.: _____
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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 _____