

**FAMILY REGISTRATION FORM**

Responsible Party \_\_\_\_\_  
First Name                      Initial                      Last Name                      Birthdate

Street Address \_\_\_\_\_ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (E-Mail) \_\_\_\_\_

(Work) \_\_\_\_\_ Can we contact you at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Name & Address of nearest relative (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse Name \_\_\_\_\_ E-Mail \_\_\_\_\_

Phone: (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Can we contact you at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

**FAMILY MEMBER INFORMATION**

<u>First Name</u>	<u>Last Name</u>	<u>Sex</u>	<u>Relationship</u>	<u>Marital Status</u>	<u>Birthdate</u>
			I - Insured	S - Single	
			S - Spouse	M - Married	
			C - Child	D - Divorced	
				W - Widowed	

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

(5) \_\_\_\_\_

(6) \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Subscriber Name \_\_\_\_\_ S.S. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone # \_\_\_\_\_

Does this plan cover all family members? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please specify those NOT covered.

**ADDITIONAL DENTAL INSURANCE INFORMATION**

Subscriber Name \_\_\_\_\_ S. S. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone # \_\_\_\_\_

Does this plan cover all family members? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please specify those NOT covered.

**AUTHORIZATIONS**

I hereby authorize payment directly to Gary Adiska DDS, PC from my insurance carrier for services rendered. I understand that I am responsible for all costs of treatment not covered by my insurance carrier. The information on this page is correct to the best of my knowledge. I grant the right of this office to release my medical and/or dental history and other information about my dental treatment to third party payers and/or health professionals.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Note: As a courtesy to our patients, we will bill your insurance company for their expected portion, your co-pay is due at the time of service. A 24 hour notice of cancellation is required to avoid a \$50.00 broken appointment fee.**

**Signed:** \_\_\_\_\_