FAMILY REGISTRATION FORM

RESPONSIBLE PARTY

Full Name:_____Birthdate:_____

Street Address_____ P.O. Box _____ City _____ State ____ Zip:_____

Phone: (Home) _____ (Cell) _____ (E-Mail)_____

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

Driver's License # _____ Social Security # _____

Employer Name_____

Employer Address_____

Emergency Contact: _____Phone_____

How did you hear about 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

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

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

DENTAL INSURANCE INFORMATION

Subscriber Name _____ Birthdate _____

Member ID # _____ S.S. # _____

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 _____Birthdate _____

Member ID #_____S.S. #_____

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_____

Broken Appointment Policy

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: _____Date_____