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. ☐Mrs.	☐Miss ☐Ms.	Birth date: / /	Age:	Sex: M☐ F☐

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

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.:
		( )	( )

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*

I give permission for my photos to be used on Dr. Charles Ruff's social media pages. ___ *Patient or Parent/Guardian Initials*