Charles J Ruff, DMD

CHILD REGISTRATION FORM

(Please Print)

Today's date:	Name of general dentist:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth date: / /	Age:	Sex: M☐ F☐
Home phone no.:	Name of school:				
Street address:	City:	State:	ZIP Code:		
Chose office because/referred by (please check one box):	☐ Dr.		☐Friend		
☐ Family	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:		Nickname:			

FIRST CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Last name:	First name:	Address (if different):	Home phone no.:
Cell phone no.: ( )	Email address:	Relationship to patient:	Yrs/Mo at address:
Occupation:	Employer:	Yrs/Mo employed:	Date of birth:
Work phone no.: ( )	Social Security no.:	Marital status (please check one box) Single☐ Married☐ Divorced☐ Sep☐ Widow☐	

SECOND CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Last name:	First name:	Address (if different):	Home phone no.: ( )
Cell phone no.: ( )	Email address:	Relationship to patient:	Yrs/Mo at address:
Occupation:	Employer:	Yrs/Mo employed:	Date of birth:
Work phone no.: ( )	Social Security no.:	Marital status (please check one box) Single☐ Married☐ Divorced☐ Sep☐ Widow☐	

DENTAL INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

Primary subscribers last name:	First name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: Spouse☐ Child☐ Other☐		Insurance co. name:		
Secondary subscribers last name:	First name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: Spouse☐ Child☐ Other☐		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 son/daughter's photos to be used on Dr. Charles Ruff's social media pages. _____ Parent/Guardian Initials