GARTNER ORTHODONTICS, LTD.
REGISTRATION FORM – ADULT

Patient's Name_____ **Date of Birth** _____
Last **First** **M.I.**

How to you wish to be addressed? _____

Address _____
City _____ **State**____ **Zip**_____
Home Tel # _____ **Cell #** _____

Single ( ) **Married ( )** **Separated ( )**
Divorced ( ) **Widowed ( )**

Employer _____
Position _____ **# yrs** ____
Telephone # _____
Soc. Sec. # _____

Spouse Name _____
Employer _____
Position _____ **# yrs** ____
Telephone # _____
Soc. Sec. # _____

DENTAL Insurance 1st Coverage

Employee Name_____
Employee Date of Birth _____
Soc. Sec. # _____
Employer _____
Insurance Co. _____
Address _____
Tel. # _____
Union, Local, Group, Policy # _____

DENTAL Insurance 2nd Coverage

Employee Name _____
Employee Date of Birth _____
Soc. Sec. # _____
Employer _____
Insurance Co. _____
Address _____
Telephone #_____
Union, Local, Group, Policy #_____

Who is responsible for this account? _____
Other family members in this practice? _____
Whom may we thank for this referral? _____
Someone to notify in case of emergency? _____
Telephone # _____ **Relationship** _____

RELEASE:

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dental care ( ). I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits ( ).

I understand that I am responsible for all costs of treatment ( ).

I attest to the accuracy of the information on this page.

SIGNATURE _____ **DATE** _____