Today's Date:_____

Monmouth Dental

Adult Registration Form

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

Patient's Legal Name:_____ Preferred Name:_____ Male ☐ Female ☐
Last First

Birth date:____/____/_____ Age:_____ SS#_____-_____-_____ Email:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone(_____)_____-_____ Cell Phone(_____)_____-_____

Appointments should be confirmed by
☐ Text Cell ☐ Call Cell ☐ Call Home

NEW PATIENTS

Previous/Current Dentist:_____ Last Visit Date:_____

How did you hear about us?_____

Other Family Members Seen by Us:_____ _____ _____

SPOUSE

Legal Name:_____ Birth date: ____/____/_____ SS#:_____-_____-_____
Last First

Cell Phone:(____)_____-_____ Employer:_____ Wk#(_____)_____-_____

DENTAL INSURANCE (PRIMARY)

Insured's Name:_____ Relation:_____ Insured's DOB:____/____/_____

SS#:_____-_____-_____ Insured's Employer:_____

Insurancy Company:_____ ID:_____ Group#_____

Insurance Company Address:_____ City:_____

State:_____ Zip Code:_____ Phone # (_____)_____-_____

DENTAL INSURANCE (SECONDARY)

Insured's Name:_____ Relation:_____ Insured's DOB:____/____/_____

SS#:_____-_____-_____ Insured's Employer:_____

Insurancy Company:_____ ID:_____ Group#_____

Insurance Company Address:_____ City:_____

State:_____ Zip Code:_____ Phone # (_____)_____-_____

CONTACT IN CASE OF EMERGENCY

Name:_____ Relation: _____Phone # (____)_____-_____

The following persons are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name:_____ Relation_____Name:_____ Relation_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time service is rendered.

Patient Signature:_____ Date:_____