



Dr. Charlie Ruff CHILD REGISTRATION FORM

(Please Print)

Today's date:	Name of general dentist:
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PATIENT INFORMATION

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

Last name:	First name:	Address (if different):	Home phone no.:
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Cell phone no.:	Email address:	Relationship to patient:	Yrs/Mo at address:
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Occupation:	Employer:	Yrs/Mo employed:	Date of birth:
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Work phone no.:	Social Security no.:	Marital status (please check one box) Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Sep <input type="checkbox"/> Widow <input type="checkbox"/>
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SECOND CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Last name:	First name:	Address (if different):	Home phone no.:
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Cell phone no.:	Email address:	Relationship to patient:	Yrs/Mo at address:
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Occupation:	Employer:	Yrs/Mo employed:	Date of birth:
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Work phone no.:	Social Security no.:	Marital status (please check one box) Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Sep <input type="checkbox"/> Widow <input type="checkbox"/>
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DENTAL INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

Primary subscribers last name:	First name:	Birth date:	Group no.:	Policy no.:
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Patient's relationship to subscriber: Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Insurance co. name:
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Secondary subscribers last name:	First name:	Birth date:	Group no.:	Policy no.:
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Patient's relationship to subscriber: Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Insurance co. name:
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IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Cell phone no.:
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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.

<i>Patient/Guardian signature</i>	Revised 9/2013
<i>Date</i>	

I give permission for my son/daughter's photos to be used on Dr. Charles Ruff's social media pages. _____ Parent/Guardian Initials