

**ADULT Account Registration Form**

Today's Date: \_\_\_\_\_

Print it out, Fill in Information and Fax to: **610-337-3863** - Or bring with you to appointment.

Patient's Name		Social Sec #	
Address		Home Tel#	
Date of Birth		Cell #	
Employer		How long there?	
Work Address		Work Tel#	
Your Occupation		Status (Circle One)	Minor / Single / Married Divorced / Separated Widowed
Email Address		Spouse's Name	
Primary Emergency Contact Person & Tel #		Secondary Emergency Contact & tel	
Primary Care Physician & Tel #		Primary Language Spoken	
Whom may we thank for referring you?			
Enter Names/Ages of Children if any			

**Person responsible for payment of account**

Name:		Social Security #	
Relationship to patient		Driver's License #	
Billing Address			
Payment Method	Check / Cash / Credit Card (enter Card #) _____ Exp: ____		

**Dental Insurance Information**

Primary Dental Insurance Co.		Group #	
Insured's Name		ID#	
Relationship to Patient		Birth Date	
Secondary Insurance Co.		Group #	
Insured's Name		ID#	
Relationship to Patient		Birth Date	

I hereby authorize payment directly to the dentists of Upper Merion Dental Associates of the group insurance benefits otherwise payable to me.

X \_\_\_\_\_ (Insured's Signature)

It is the policy of our office that the parent or guardian who accompanies the child and requests treatment is responsible for payment of all fees at the time of service unless prior arrangements have been approved. In case of default of this account, I agree to pay collection costs on the outstanding balance.

X \_\_\_\_\_ (Signature of Parent/Guardian)