REGISTRATION – ADULT

OOSTBURG FAMILY DENTISTRY
DANIEL R. BRUHN, D.D.S.
JORDAN D. MOLTER, D.D.S.

Today's Date:			
PATIENT INFORMATION			
Last Name:		First:	Middle:
Date of Birth:	Age:	Sex: ❒ M ❒ F	Marital Status:
Street Address:			
City:		State:	ZIP Code:
Primary Phone: cell hm		Work Phone:	
Email address (*NOT for marketing*):			
Occupation:	Employer:		City:
Family members who are patients here:			
How did you learn about our practice?			
SPOUSE INFORMATION			
Last Name:	First:		Middle:
Date of Birth:	Employer:		City:
INSURANCE INFORMATION: Please present your insurance card to the receptionist.			
Is patient covered by a dental plan? **Yes No**		Insurance Company:	
Name of Insured:		Insured's Date of Birth:	
Insured's Address (*if different*):			
Insured's Employer:		City:	
Is patient covered by a second dental plan? **Yes No**		Insurance Company:	
Name of Insured:		Insured's Date of Birth:	
Insured's Address (*if different*):			
Insured's Employer:		City:	
WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?			
Name:		Relationship to patient:	
Primary Phone: cell hm		Work Phone:	

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance. I authorize Oostburg Family Dentistry and my insurance company to release any information required to process my claims.

_____ _____

Patient or Guardian Signature Date

revised July 2023