

FAMILY ORTHODONTIC CARE, P.C.

JEREMIAH J. LOWNEY, JR., D.D.S., M.S.

JENNIFER J. LOWNEY, D.M.D.

MARK E. FISCHER, D.M.D., M.S.

SUSAN J. DAVIS, D.M.D., M.S.

100 Sherman Street
Norwich, Connecticut 06360
(860) 886-1466

79 Norwich Avenue
Colchester, Connecticut 06415
(860) 537-1918

**ADULT REGISTRATION FORM
(PLEASE PRINT & BRING WITH YOU TO APPOINTMENT)**

Date: ___/___/___

Patient Name-Last _____ First _____ MI _____

Patient Address _____

Home Phone No. _____ Cell Phone _____ DOB ___/___/___ Age _____ Sex _____

S.S.# _____ Emergency Contact Name _____ Phone _____

Employer _____ Business Phone _____ Can we call you at work? Yes / No

Employer Address _____ Occupation: _____

Marital Status: Single Married Widowed Divorced

Spouse/Parent Name _____ DOB ___/___/___ S.S.# _____

Address (if different than patient) _____

Bus. Phone _____ Cell Phone _____

Employer _____ Can we call at work? Yes / No

Employer Address _____

INSURANCE

PRIMARY INSURANCE

Name of Insurance Company _____ Orthodontic Max:\$ _____

Insurance Address _____

Subscriber's Name _____ DOB ___/___/___ Relationship to Patient _____

S.S.# _____ ID# _____ GROUP# _____

Employer Name & Address: _____

SECONDARY INSURANCE

Name of Insurance Company _____ Orthodontic Max:\$ _____

Insurance Address _____

Subscriber's Name _____ DOB ___/___/___ Relationship to Patient _____

S.S.# _____ ID# _____ GROUP# _____

Employer Name & Address: _____

AUTHORIZATIONS

I authorize Family Orthodontic Care, PC to release my protected health information to my dental benefit plan needed to carry out payment activities in connection with dental services rendered. I also agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

X _____
Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Family Orthodontic Care, P.C.

X _____
Subscriber Signature Date

Family Orthodontic Care may call my business phone to reach me during the day to discuss treatment, scheduling, or account issues regarding myself / my child.

X _____
Patient/Guardian Signature Date

ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of Family Orthodontic Care's **Notice of Privacy Practices**. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient Name: _____ Parent/Guardian Name _____
(Please Print) If under 18 (Please Print)

Signature _____ Date _____
(Parent/Guardian if under 18)

Relationship to Patient _____