

**DONOHUE & DONOHUE D.D.S., PC**  
**Terry J. Donohue DDS, Timothy M. Donohue DDS, Kelly M. Donohue DDS**  
323 West Maple Street, P.O. Box 848 Carson City, MI 48811  
989-584-3171 Office 989-584-3013 Fax  
**Adult Patient Registration Form**

**WELCOME TO OUR PRACTICE**

Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
(First) (MI) (Last)

Drivers Lic #: \_\_\_\_\_ Sex: Male / Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (P.O. Box) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: Married Single Divorced Widowed Separated Maiden Name: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Preferred Method of Contact (please circle best options) **Cell Home Work Email Text**

May we contact you at work if needed? Y N

May we send email/text correspondence regarding appointments? Y N

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

In the event of an emergency, whom should we contact? Name: \_\_\_\_\_

Phone : \_\_\_\_\_ Address: \_\_\_\_\_

**Person responsible for bill** \_\_\_\_\_

**Insurance Information:**

Name of Primary Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured's Soc. Sec. #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Name of Secondary Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Sec. Insured's Soc. Sec. #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Sec. Insured's Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Sec. Insurance Co. Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Authorization and Release**

I authorize the dentist and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent. I authorize the dentist and staff to release any information including diagnosis and records of any treatment or examination rendered to third party payers and/or other health practitioners. I authorize and request my dental benefits company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to myself, or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. A copy of our financial policy is available upon request.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian if a Minor

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