

PATIENT REGISTRATION

Patient's name _____ Birthdate _____ Single
Name of spouse _____ Birthdate _____ Widowed
If a child, parent's name _____ Married
Divorced
Separated

Street address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____ E-mail _____

Patient employed by _____ Phone _____

Present position _____ How long held _____

Business address _____

Spouse employed by _____ Phone _____

Present position _____ How long held _____

Business address _____

Purpose of this appointment _____

In case of emergency, who should be notified _____ Phone _____

Person responsible for this account _____

Social Security number _____

Drivers License number _____

Spouse's Social Security number _____

Spouse's Drivers License number _____

If using charge card, name _____ Card no. _____ Exp. Date _____

If you have insurance, name of insured _____

Name of insurance company _____ Policy number _____

Is policy connected with a Union? Yes ___ No ___ If yes, name of Union _____

Local no. _____ Group no. _____

If spouse has insurance, name of insured _____

Name of insurance company _____ Policy number _____

Is policy connected with a Union? Yes ___ No ___ If yes, name of Union _____

Local no. _____ Group no. _____

Whom may we thank for referring you? _____

What expectation do you have of a dental practice? _____

What is the key in having you remain as a long term patient? _____

Can you tell me about some good experiences you have had in a dental office? _____

Are there any experiences that have been negative? Please describe them. _____

Comments: _____

I understand that, where appropriate, credit bureau reports may be obtained.

Your Signature (Parent's Signature, if minor) _____ Date _____

Updates (date and initial) _____