

PATIENT REGISTRATION
Please Print and Answer All Questions

account# _____

Patient: _____ Mr. Mrs. Miss
 Single Married Divorced Widowed Separated **Birthdate:** _____ **Age:** _____
Spouse's name: _____ **Parent name (if minor):** _____

Home Address _____
City _____ State _____ Zip Code _____ Home Phone: _____
Cellular/Pager Number: _____

Patient Employer: _____ Occupation: _____
Employer Address: _____ Phone: _____
Spouse or Parent Employer: _____ Occupation: _____
Employer Address: _____ Phone: _____

Patient's Social Security Number: _____ Drivers License: _____

⌘ *How did you hear about our office?* _____ E-mail address: _____
If we need to send any statement or other correspondence to you, would you prefer:
⌘ *Whom may we thank for referring you?* _____ US MAIL _____ or EMAIL _____

In case of emergency, nearest friend or relative other than spouse, at a different address:
Name: _____ Relationship: _____
Address: _____ Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship to patient: _____
Home Address: _____ City/State: _____ Zip: _____
Mailing Address (if different): _____
Home Phone: _____ Business Phone: _____ Social Security Number: _____

DENTAL INSURANCE

Primary Insurance Company: _____ Group #: _____
Subscriber Name: _____ ID#: _____
Birthdate: _____ Employer: _____ Patient relationship to subscriber: _____
Secondary Insurance Company: _____ Group #: _____
Subscriber Name: _____ ID #: _____
Birthdate: _____ Employer: _____ Patient relationship to subscriber: _____

⌘ If injured, Date of injury: _____ Cause/Place: _____

How will you be paying for your service today?

Cash Check VISA/MASTERCARD DISCOVER CARD AMERICAN EXPRESS CARE CREDIT

I request consideration for credit policies extended by the Doctor and desire credit extended to me and/or my family for services rendered. I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that Douglas Walsh, DDS may add one and eight-tenths percent (1.8%) per month to any balance owed and in the event of default to pay reasonable collection charges and attorney fees.

Signature: _____ **Date:** _____