DOUGLAS C. WENDT, JR., D.D.S.

Practice Limited to Periodontics &
Implant Dentistry

PATIENT REGISTRATION

Patient's name____ **Birthdate**______________________
Single __ **Widowed** ___ **Married** ___ **Divorced** ___ **Seperated** ___
Name of spouse____ **Birthdate**______________________
If a child, parent's name____
Street Address____ **Phone**___________________
City______________________________________ **State**________________ **Zip**____________________
Patient employed by____ **Phone**___________________
Business address____
Present position____ **How long held**___________
Spouse employed by____ **Phone**___________________
Business address____
Present position____ **How long held**___________
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 you have insurance, name of insured____
Name of insurance company________________________________ **Policy no.**____________________
Whom may we thank for referring you____

Your Signature____ **Date**_______________________

Comments:____
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