

Registration Form
For the Practice of Dr. Albert B. Boholst

Patient Name: _____ Date: ___/___/___
(First) _____ (Middle Initial) _____ (Last) _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Social Security # _____
Telephone (Home) _____ Work _____ Birthdate ___/___/___ Sex ___
Email address _____
Marital Status ___ Single ___ Married ___ Widowed ___ Divorced
Employed By _____
Business address _____
City _____ State _____ Zip _____
Full time student? ___ Yes ___ No If so, which school? _____

Who may we thank for referring you to our office? _____
What are your hobbies/interests? _____
What is the reason for today's visit? _____
Do you have any questions or concerns we can help you with today? _____

How do you feel about your smile and overall dental health? _____
Would you like whiter teeth? _____ (If yes, ask for free brochure)
What would you like to change in your mouth? _____
Why did you leave your last dentist? _____
What did you like *most* about your last dentist? _____
What did you like *least* about your last dentist? _____

Spouse or Guardian's Information

(Must be completed if patient under 18 or not the responsible party)

Name _____ Social Security # _____
Occupation _____ Work # _____ Birthdate ___/___/___
Employer and Employer's Address _____

Dental Insurance Information

Insured is ___ self ___ husband ___ wife ___ mother ___ father
Employee's Name _____ Social Security # _____
Date employed ___/___/___ Birthdate ___/___/___
Insurance Co. _____ Group # _____
Insurance Co. Address _____ Insurance Co. Ph# _____
Are you covered by a second insurance company? ___ Yes ___ No
If yes, 2nd Insurance Co. _____
Employee name for 2nd insurance co. _____
Social Security # for 2nd insurance co. _____ Birthdate ___/___/___
Date Employed ___/___/___