JOHN M PISACANE, DMD
1245 Lincoln Ave., Suite 150
San Jose, CA 95125
408-293-9600

Willow Glen Dentistry

REGISTRATION

DATE ____________

PATIENT'S NAME ____________ SINGLE ___ WIDOWED ___ MARRIED ___ DIVORCED ___ SEPARATED ___

PREFERRED NAME ____________

IF A CHILD, PARENT'S NAME & CHILD'S SCHOOL ____________

STREET ADDRESS ____________ HOME PHONE ____________

CITY ____________ STATE ____________ ZIP ____________

PATIENT (OR PARENT) EMPLOYED BY ____________ BUSINESS PHONE ____________

BUSINESS ADDRESS ____________ CELL PHONE/PAGER # ____________

PRESENT POSITION ____________ HOW LONG HELD ____________

PATIENT'S SOCIAL SECURITY NUMBER: ______-______-______ E-MAIL ADDRESS ____________

NAME OF SPOUSE ____________

SPOUSE EMPLOYED BY ____________ PHONE ____________

BUSINESS ADDRESS ____________ EMAIL ADDRESS ____________

PRESENT POSITION ____________ HOW LONG HELD ____________

SPOUSE'S SOCIAL SECURITY NUMBER ____________ CELL PHONE/PAGER # ____________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY
NOT LIVING WITH YOU ____________ PHONE ____________

WHO WILL PAY THIS ACCOUNT ____________

WHOM MAY WE THANK FOR REFERRING YOU ____________

ARE ANY MEMBERS OF YOUR IMMEDIATE FAMILY PATIENTS IN THIS OFFICE? ____________

PURPOSE OF THIS APPOINTMENT: ____________

DENTAL INSURANCE 1ST COVERAGE	DENTAL INSURANCE 2ND COVERAGE
EMPLOYEE NAME ____________	EMPLOYEE NAME ____________
EMPLOYEE DATE OF BIRTH ____________	EMPLOYEE DATE OF BIRTH ____________
EMPLOYER ____________	EMPLOYER ____________
NAME OF INSURANCE CO. ____________	NAME OF INSURANCE CO. ____________
PROGRAM OR POLICY # ____________	PROGRAM OR POLICY # ____________
UNION LOCAL OR GROUP ____________	UNION LOCAL OR GROUP ____________
SOCIAL SECURITY NUMBER ____________	SOCIAL SECURITY NUMBER ____________

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGE DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms c reports to help you to obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay a our fees. Each fee is individual for the individual patient.

CONSENT

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinica and dental laboratories, pharmacies or other health care personnel providing you treatment.

____________ PATIENT'S SIGNATURE (PARENT IF MINOR) ____________ DATE

PLEASE COMPLETE REVERSE SIDE