

PLEASE PRINT THIS FORM, FILL OUT AND BRING WITH YOU TO OFFICE

PATIENT REGISTRATION AND HEALTH HISTORY

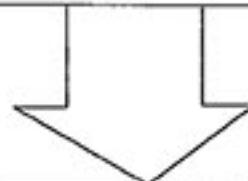
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE		1	
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL PHONE NO.	
E-MAIL ADDRESS		DAYTIME NO.	
BIRTH DATE	AGE		
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
PREFERRED CONTACT METHOD (CHECK ONE)			
WORK PHONE	E-MAIL	HOME PHONE	
	TEXT MESSAGE	CELL PHONE	
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTH DATE	AGE	GRADE	
SCHOOL			
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
EMPLOYEE		
EMPLOYER		
GROUP NO.		
EMP. DATE OF BIRTH		
DATE EMPLOYED		
EMP. SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
EMPLOYEE		
EMPLOYER		
GROUP NO.		
DATE EMPLOYED		
EMP. SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
YOUR:		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	
YOUR SPOUSE:		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS TELEPHONE	EXT.	

GETTING TO KNOW YOU			3
IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE?			
THEIR NAME:			
REFERRED TO US BY			
YOUR FORMER ADDRESS			
CITY	STATE	ZIP	
PERSON TO CONTACT FOR EMERGENCY			
PHONE NUMBER			
ADDRESS			
CITY	STATE	ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU			
PHONE NUMBER			
ADDRESS			
CITY	STATE	ZIP	