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

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

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 (CIRCLE 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

2

DENTAL INSURANCE

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.

3

GETTING TO KNOW YOU

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

4

ACCOUNT INFORMATION

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.