

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

Date
Name
Address
City State Zip
Home Phone # Cell Phone #
Birthdate Age M F
Married Single Divorced Widowed
Patient's Social Security #
Occupation
Employer
How long in present place of employment?
Business Address City
Business Telephone # Ext
Spouse's Name
Occupation
Employer
Business Address City
Business Telephone # Ext



Purpose of Visit
Last Dental Examination was on
former Dentist



Referred to us by:
Is another member of your family or relative a patient at our office?
Name Relationship
Person to contact for emergency
Home Telephone # Business Telephone #
Address
City State Zip
Closest Relative not living with you
Home Telephone # Business Telephone #
Address
City State Zip



ACCOUNT INFORMATION PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
Name		
Home Address		
City State Zip		
Home Telephone #		
Relationship to Patient		
Business Address		
City State Zip		
Business Telephone #		
Dental Insurance Carrier Name		
D.O.B. for Primary Carrier		
Employee's Name		
Social Security #		

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

Date
Name of Child
Address
City State Zip
Home Telephone #
Birthdate Age Grade M F
School

**AS PARENT OR LEGAL GUARDIAN,
PLEASE FILL IN TOP BOX ALSO.**

e-mail address:

Would you like to be notified of your next dental appointment by e-mail? Yes No
We will only use your address for dental purposes.
We will not release your address to anyone.

PLEASE SEE OTHER SIDE FOR HEALTH HISTORY INFORMATION. **THANK YOU**