Health History & Registration

Patient Information

Patient's Name. LAST ___________________________ FIRST___________________________ MIDDLE INITIAL_________

Birthdate ________________ Marital Status _______ Social Sec. # __________________ Driver's License# ___________

Residence STREET___________________________ APT # _____ CITY_________________ STATE_____ ZIP __________

Mailing STREET___________________________ APT # _____ CITY_________________ STATE_____ ZIP __________

(If Different than Residence)

Home Phone ___________________ Cell Phone ___________________ Work Phone _________________

Email Address ____

Employer ___________________________ Occupation ___________________________ Years Employed ________

If Patient is a Minor, give Parent's or Guardian's Name ____________________________

Whom May We Thank for Referring You to our Office ________________________

Reason for this Visit ___________________________

Responsible Party (if different than Patient)

LAST ___________________________ FIRST ___________________________ MIDDLE INITIAL ________

Birthdate ________________ Marital Status _______ Social Sec. # __________________ Driver's License# ____________

Residence STREET ___________________________ APT # _____ CITY _________________ STATE _____ ZIP _________

Mailing STREET ___________________________ APT # _____ CITY _________________ STATE _____ ZIP _________

(If Different than Residence)

Home Phone ___________________ Cell Phone ___________________ Work Phone __________________

Email Address ____

Employer ___________________________ Occupation ___________________________ Years Employed __________

Responsible Party's Spouse

LAST _________________________FIRST _________________________

Employer ______________________ Occupation __________________

Social Security # _______________________ Birthdate ____________

Home Phone __________________ Cell Phone ___________________

Work Phone ___________________

Emergency Contact: Relative Not Living with You

Name ____________________ Relationship ________

Address ______________________________

____

Home Phone ____________________

Cell Phone ______________________

Dental Insurance Information

Insured's Name ____

Insurance Company ____

Insured's Employer ____

Insured's Social Security #____________________________________

Group # ___________ Contract# ________