

# PATIENT REGISTRATION AND HEALTH HISTORY

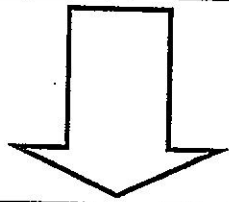
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

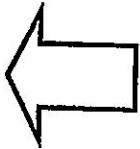
DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

<b>DENTAL INSURANCE</b>	
<b>PRIMARY CARRIER</b>	
INSURANCE COMPANY	
INSURANCE ADDRESS	
GROUP NO.	EMPLOYEE
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	
<b>SECONDARY CARRIER</b>	
INSURANCE COMPANY	
INSURANCE ADDRESS	
GROUP NUMBER	EMPLOYEE
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	



<b>ACCOUNT INFORMATION</b>	
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY	STATE ZIP
PHONE NO.	
<b>YOU</b>	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	
BUSINESS PHONE NO.	
<b>YOUR SPOUSE</b>	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	
BUSINESS PHONE NO.	



<b>GETTING TO KNOW YOU</b>	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
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