# PATIENT REGISTRATION AND HEALTH HISTORY

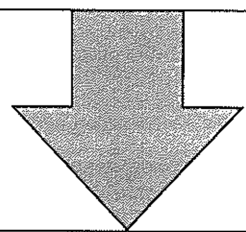
**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

| DATE | | | 1 |
|---|---|---|---|
| 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 |

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

| DENTAL INSURANCE 2 |
|---|
| **PRIMARY CARRIER** |
| INSURANCE COMPANY |
| EMPLOYEE |
| DATE OF BIRTH |
| GROUP NO. |
| UNION OR LOCAL NO. |
| DATE EMPLOYED |
| EMP. SOCIAL SECURITY NO. |
| **SECONDARY CARRIER** |
| INSURANCE COMPANY |
| EMPLOYEE |
| DATE OF BIRTH |
| GROUP NO. |
| UNION OR LOCAL NO. |
| DATE EMPLOYED |
| EMP. SOCIAL SECURITY NO. |



| GETTING TO KNOW YOU | | 3 |
|---|---|---|
| **IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?**<br>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 |

| ACCOUNT INFORMATION | 4 |
|---|---|
| **PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT** | |
| NAME | |
| DRIVERS LICENSE NO. | RELATIONSHIP TO PATIENT |
| BANK | |
| BRANCH | |
| ACCOUNT NO. | |
| **YOU:** | |
| NAME | |
| OCCUPATION | |
| EMPLOYER | |
| BUSINESS ADDRESS | CITY |
| BUSINESS TELEPHONE | EXT. |
| **YOUR SPOUSE:** | |
| NAME | |
| OCCUPATION | |
| EMPLOYER | |
| BUSINESS ADDRESS | CITY |
| BUSINESS TELEPHONE | EXT. |

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