PATIENT HISTORY INFORMATION

PLEASE PRINT

PATIENT'S NAME________ HOME #________ CELL #________

SS#________ BIRTHDATE________ AGE____ SEX____ MARITAL STATUS____

ADDRESS________ CITY________ STATE____ ZIP________

EMAIL________

PATIENT'S EMPLOYER________ WORK PHONE________

SPOUSE'S NAME________ SPOUSE'S EMPLOYER________

PERSON TO NOTIFY IN CASE OF EMERGENCY________ PHONE________

STUDENT: ☐ FULL TIME ☐ PART TIME SCHOOL________ CITY________

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES, WHEN?________

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT________

LAST FIRST MIDDLE

RELATIONSHIPTOPATIENT________ HOME#________ WORK#________ CELL#________

ADDRESS________ CITY________ ZIP________

EMAIL________

SS#________ DOB________ DRIVER'S LICENSE No.________

EMPLOYER________ OCCUPATION________

EMPLOYER'S ADDRESS________ CITY________ ZIP________

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ YES ☐ NO

NAME________ WHEN?________

DENTAL INSURANCE ☐ YES ☐ NO________

INSURED'S NAME ________ CELL#________

SS# ________ DOB________

EMPLOYER________

INS. CO. or PLAN ________

UNION/GRP. NAME________

GRP. or POLICY #________ LOCAL # ________

DATE EMPLOYED________

SECONDARY INSURANCE ☐ YES ☐ NO

INSURED'S NAME ________ CELL#________

SS# ________ DOB________

EMPLOYER ________

INS. CO. or PLAN________

UNION/GRP. NAME ________

GRP. or POLICY #________ LOCAL # ________

DATE EMPLOYED ________

HOW DID YOU HEAR ABOUT THIS OFFICE: ☐ FORMER PATIENT (WHO?________)

☐ UNION ☐ TELEPHONE BOOK ☐ SAW BLDG./SIGN ☐ EMPLOYER

☐ ADVERTISEMENT (WHICH?________)

☐ OTHER________

WHY ARE YOU HERE TODAY?________

CHECK UP, TOOTHACHE, CONSULTATION, ETC.