HEALTH HISTORY AND PATIENT REGISTRATION FORM

ACCOUNT NUMBER:_____

Date: _____ Cell # _____

Name: _____

Mailing Address: _____

Street Address: *(if different)*: _____

City:_____State:_____Zip: _____

Home Phone:_____Business Phone: _____

Previous Address if less than three years: _____

Please circle one: Single Married Widowed Separated Divorced

Place of Employment, Address, Phone #: _____

_____

Social Security #:_____Drivers License #: _____

Birthdate:_____Sex:_____Height:_____Weight:_____Age: _____

MEDICAL ALERT

SPOUSE OR PARENT:

Name:_____Birthdate:_____Social Security #: _____

Place of Employment, Address, Phone #: _____

Closes Relative not living with you: _____ Address:_____

Telephone No.:_____

RESPONSIBLE PARTY:

Name: _____ Address *(if different than above)*:_____

Method of Payment *(check one)* Cash ❒ Check ❒ Bank Card ❒_____

REFERRED BY: Doctor (name) _____ Patient_____Staff_____

Advertisement (location) _____ Sign_____Yellow Pages_____Other_____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

_____

Insured's Employer: _____

Group or Policy #: _____

Insurance Co. Phone #: _____

MEDICAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

_____

Insured's Employer: _____

Group or Policy #: _____

Insurance Co. Phone #: _____

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only, and will be considered confidential. These facts have a direct bearing on your dental health.

	DATE / /	DATE / /
1. Are you in good Health?	Yes ❒ No ❒	Yes ❒ No ❒
2. Has there been any change in your general health within the year?	Yes ❒ No ❒	Yes ❒ No ❒
3. My last physical examination was on (approx. date) _____		
4. Are you now under a physician's care?	Yes ❒ No ❒	Yes ❒ No ❒
If yes, for what condition? _____		
5. The name and address of your physician is _____		
_____		
6. Have you had any serious illness or operation?	Yes ❒ No ❒	Yes ❒ No ❒
If so, please list the name of the illness or operation _____		
7. Have you been hospitalized or had a serious illness within the past five years?	Yes ❒ No ❒	Yes ❒ No ❒
8. Have you had any history of Tumors, Malignancies, or treatment for cancer of any nature?	Yes ❒ No ❒	Yes ❒ No ❒