ADULT REGISTRATION & MEDICAL HISTORY

(please print)

Date _____ Home phone (___)_____

Patient's Name _____
last first middle preferred name

Date of Birth_____ Age_____ Marital Status_____ Sex_____

Home Address _____ City_____ State_____ Zip_____

Occupation_____ Employer Name_____

work number_____ and Address_____

Mobil#/Pager#_____ _____

Spouse_____ Spouse's Date of Birth _____

Spouse Employer_____ Work number_____

Person financially responsible_____ Relation_____

Address, if different from above_____

E-mail _____ Children - Names/Ages

Social Security # Mr._____ 1._____

Mrs._____ 2._____

Drivers License # Mr._____ 3._____

Mrs._____ 4._____

Whom may we thank for referring you?_____

Reason for today's appointment_____

Name of nearest relative not living with you_____ Relation_____

Relatives Address_____

Relatives home number _____ Relatives work number_____

**********FOR PATIENTS WITH DENTAL INSURANCE**********

Name of policy holder_____ Social Security #_____

Name of group plan_____ Union or Group #_____

Mailing Address of Insurance Co. (Name, street address and/or P.O. Box, City, State and Zip Code)

_____

Phone Number _____

PLEASE NOTE:

Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from them, you will be asked to pay a percentage of the charges before your treatment is completed.