

Health History and Registration

DATE _____

Birth Date _____

NAME _____ Home Phone()- _____

Last First Middle

Address _____ Bus. Phone()- _____

City _____ State _____ Zip Code _____

Sex M F Height ___ Weight ___ Marital Status ___ Spouse Name _____

Social Security Number _____ (Parent Name-Minor)

Employer _____ Occupation _____

Business Address _____ Driver's Lic. No. _____

Person Responsible for Account _____

How did you hear about our office? _____

REASON FOR VISIT _____

EMERGENCY INFORMATION

Name, address & telephone of a _____

relative not living with you _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Birth Date _____

Insured's Social Security No. _____ Group# _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

I authorize dental information about me to be released to my insurance company or its representatives if needed to determine benefits payable for dental services. I understand that I am responsible for any payment not covered by the insurance company. I also understand that under certain circumstances, payment may be required prior to the receipt of services. (Parent signature, if minor)

Patient Signature _____ Date _____

MEDICAL HISTORY

Physician's Name _____ Phone# ()- _____

Address _____

Are you currently under the care of a physician ___ Yes ___ No

What reason? _____

My general health is ___ Excellent ___ Good ___ Fair ___ Poor

My last medical examination was (date) _____ (reason) _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?

___ Yes ___ No If so, what was the reason? _____

Are you taking any medicine(s) including prescription or non-prescription ___ Yes ___ No

If so, what Medicine(s) are you taking? _____

Have you ever taken Fen-Phen or Redux? ___ Yes ___ No

