REGISTRATION AND HEALTH HISTORY

Patient Name: First…………………………………… Middle………………… Last…………………………………………

Sex __ Male __ Female

E-Mail……………………………………………………………..

Cell Phone #.................................... Home Phone #.......................................

Resident's Address……………………………….City……………………State………..Zip…………….Birthdate………………..

Employer…….

Employer's Address…….

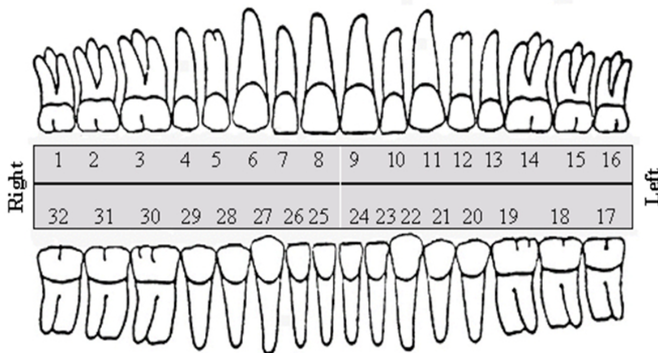
Name, Address and Phone of Husband, Wife, or Nearest Relative………………………………………………………

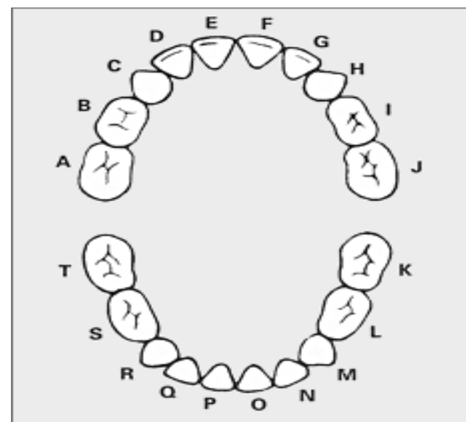
How do you hear about our office?...

Referred by:………..

Reason for this visit: __ Toothache __ Examination __ Cleaning Other:…………………………………..

Name, Address, and Phone Number of Your Medical Doctor:……………………………………………………………….





PATIENT WITH INSURANCE

Name of Insurance Co………..

Insured Name…………………………………………………………………Soc. Sec. # of Insured……………………………………

Employer of Insured……

It is understood and agreed that in the event the insurance payment is insufficient to liquidate the said account, I shall be responsible and personally liable for the unpaid balance of the account.

Signature:…………………………………………………………………………………………………….Date:…………………………