REGISTRATION HISTORY

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Patient's Full Name_____ _____ _____ Male___ Female___ Other _____
First Middle Last

Patient's Preferred name_____ Patient's Parents(if under 18)_____

Social Security #_____-_____-_____ Date of Birth_____Age_____

Mailing Address_____ _____ _____ _____
Street City State Zip Code

Home Phone_____Work Phone_____Cell Phone_____

YES/NO (please circle one): I agree to receiving text communications regarding dental appointments and dental care.

Employer_____E-Mail_____

IF COLLEGE STUDENT (name & location of college)_____Full___Part Time___

Person to contact in an emergency_____

Relationship_____ Phone #_____

Names of other children in family(if a child's history form)_____

Whom may we thank for referring you to our office? _____

Dental

Insurance Company_____

Address_____
_____

Insurance Co. Phone _____

Certificate #_____

Group #_____

Policy Holder _____ _____
First Last

Social Security# _____

Date of Birth _____

Employer _____

Relationship to Patient _____

Secondary

Insurance Company_____

Address_____
_____

Insurance Co. Phone _____

Certificate #_____

Group # _____

Policy Holder _____ _____
First Last

Social Security#_____

Date of Birth _____

Employer _____

Relationship to Patient_____