## Patient Number \_\_\_\_\_ABC HEALTH HISTORY & REGISTRATION

|  |  | PAI                 | FIENT INF   | FORMATION  |  |  |   |                |
|--|--|---------------------|---|--|--|--|---|----------------|
| PATIENT'S NAME Last  | First  |                     |   | Middle Initial   | SEX: M F   | BIRTHDATE  |   | AGE            |
| Soc. Sec. # If   | Patient is a N   | linor, giv          | e Parent's or G   | Guardian's Name  |  | TODA   | Y'S DATE  |                |
| Who may we thank for referring you to our office?  |  |                     |   | Reason for this Vi   | sit  |  |   |                |
|  | RESF   | PONS                | IBLE PAF  | RTY INFORMAT   | ION  |  |   |                |
| NAME Last  | Fi   | rst                 |   |  | Middle Initial   |  | _ MARITAL STATUS  | 3              |
| RESIDENCE Street   |  |                     | Apt. #  | City   | St   | ate  | Zip   |                |
| MAILING ADDRESS Street   |  |                     | Apt. #  | City   | St   | ate  | Zip   |                |
| HOW LONG AT THIS ADDRESS   | Н  | OME PH              | ONE   |  | CELL PHONE   | Ē  |   |                |
| WORK PHONE   |  | E-N                 | MAIL  |  |  |  |   |                |
| PREVIOUS ADDRESS (if less than 3 years) Street   |  |                     | City  |  | State Zip  |  | How long _  |                |
| SOCIAL SECURITY #  | BIRTHDATE .  |                     |   | DRIVER'S LICENSE # _   | F  | RELATION 1   | TO PATIENT  | 2.             |
| EMPLOYER   |  |                     | OCCUPATI  | ON   |  | NO. Y  | YEARS EMPLOYED  |                |
| RESPONSIBLE PARTY'S S  | POUSE  |                     |   | EMERGENCY  | INFORMATION: R   | ELATIVE  | NOT LIVING  | WITH YOU.      |
| NAMELAST FIRST   | MIDD   | N E                 |   | NAME   |  | R  | RELATIONSHIP  |                |
| EMPLOYEROCCUPATION   |  |                     | ( )<br>EARS EMPLOYED  |  |  |  |   |                |
| SOC. SEC. # BIRTHDATE  |  | HO. 11              | EARS EMPEOTED   |  |  |  |   |                |
| HOME PH CELL PH  |  |                     |   |  | CEL  | L PH   |   |                |
| WORK PH E-MAIL   |  |                     |   | WORK PH.   |  |  |   |                |
| DENTAL INSURANCE INFORMATION   |  |                     |   | 5 0 (207 50 50   | dental insurance covera  |  |   |                |
| Insured's Name   |  |                     |   |  |  |  |   |                |
| Insurance Co E   | A CONTRACTOR OF THE PARTY OF TH |                     |   |  | _  |  |   |                |
| Insurance Co. Address  |  |                     |   |  | \$   |  |   |                |
| Insured's Employer   |  |                     |   |  |  |  |   | Local #        |
|  | aroup ir   |                     | AI #  | d. 60 6 600. 600. #  |  |  | Group #   | Loodi II       |
| It is important that I know about this information is strictly confidential a  | out your Me<br>and will not  | dical ai<br>be rele | nd Dental His<br>ased to anyo   | story. These facts have<br>ne. Thank you for tak   | re a direct bearing on<br>king the time to comp  | your Der<br>letely fill  | ntal Health.<br>out this question   | naire.         |
| *DENTAL HISTORY*   | YES  | NO                  |   | *M   | EDICAL HISTORY*  |  |   |                |
|  |  | 110                 |   | 141  |  |  |   | YES NO         |
| HOW LONG SINCE you have seen a dentist?  Last COMPLETE Dental Exam. Date:  |  | 110                 |   | any CURRENT HEAL   |  |  |   |                |
| Last COMPLETE Dental Exam, Date: Last FULL MOUTH X-RAYS, DATE: (16 small films or panoran  | nic)   |                     |   |  |  |  |   |                |
| Last COMPLETE Dental Exam, Date: Last FULL MOUTH X-RAYS, DATE: (16 small films or panoran Are you having PROBLEMS now?   | nic)   |                     | Are you und<br>For what?  | any CURRENT HEAL   | RE now?  |  |   |                |
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\_\_\_ Date:\_\_\_

\_\_\_\_\_ DENTIST Signature\_

PATIENT Signature (Parent or Child) \_