REGISTRATION AND HEALTH HISTORY

Patient Name: _____ **Birth Date:** _____

Social Security #: _____ **Marital Status: S M D W (circle one)**

Address: _____ **City:** _____

_____ **State/Zip:** _____

Home #: _____ **Cell #:** _____ **Email Address:** _____

Employer: _____ **Phone #:** _____
Address: _____
Present Position: _____

Spouse's Name: _____ **Birth Date:** _____
(If Child-Guardian's Name)
Social Security #: _____

Spouse's Employer: _____ **Phone #:** _____
Address: _____
Present Position: _____

Dental Insurance Company Name: _____ **Group #:** _____
Address: _____
Name of Subscriber: _____ **Union Local:** _____

Secondary Dental Insurance Name: _____ **Group#:** _____
Address: _____
Name of Subscriber: _____ **Union Local:** _____

Are you having any discomfort at this time? _____
How long since you have been to a dentist? _____
What was done then? _____
Did you have x-rays taken at that time? _____
How often did you visit a dentist before then? _____
Is there anything you want us to know about you? _____
_____

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information given is strictly confidential and will not be released to anyone without your written permission.