# HEALTH HISTORY & REGISTRATION

**PATIENT NAME:** _____ **Preferred Name:** _____

**BIRTHDATE:** _____ **AGE:** _____ **GENDER (M / F ) Marital Status**: _____

**RESIDENCE ADDRESS**: _____

**MAILING ADDRESS:** _____ **SS#** _____

**PHONE #: Home** _____ **Cell #** _____ **is it OK to text Y or N**

**WORK #:** _____ **EXT:** _____ **EMPLOYER:** _____

**EMAIL:** _____ **would you like email reminders? Y or N**

***Who may we thank for referring you to our office?*** _____

**RESPONSIBLE PARTY/SPOUSE INFORMATION (IF DIFFERENT FROM PATIENT)**

**PATIENT NAME:** _____ **Preferred Name:** _____

**BIRTHDATE:** _____ **AGE:** _____ **GENDER (M / F) Marital Status:** _____

**RESIDENCE ADDRESS**:_____

**MAILING ADDRESS:** _____

**PHONE #: Home** _____ **Cell #** _____ **Is it OK to text Y or N**

**WORK #:** _____ **EXT:** _____ **EMPLOYER:** _____

**EMERGENCY INFORMATION: (Relative not living with you)**

**Name**: _____ **Relationship:** _____

**Phone #: Home:** _____ **Cell #:**_____

***PRIMARY INSURANCE***

**Insurance Company Name**:_____ **Phone #** _____

**Subscribers Name**: _____ **Date of Birth:** _____

**ID # or SS#** _____ **Group #** _____ **Group Name:** _____

***SECONDARY INSURANCE***

**Insurance Company Name**:_____ **Phone #** _____ **Group #** _____

**Subscribers Name:** _____ **Date of Birth:** _____ **ID #** _____

The undersigned hereby authorizes the Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated, once fully explained.

**Signed:** _____ **Date:** _____