Medical Alert For Office Use

# PATIENT REGISTRATION & HEALTH HISTORY FORM

**Please complete the following confidential patient information so that we may make your visit pleasant and comfortable.**

**How Did You Hear About Our Office?** ☐ Family/Friend (Name: _____) ☐ Mailer ☐ Referral Brochure (If Yes, From Whom?_____)
☐ Building Sign/Drive-By ☐ Website/Web Search Engine
☐ The Talking Phone Book
☐ Other (Please Explain: _____)

Today's Date:

Patient's Name: Nickname: Birth Date: Age: Sex: M F

Street Address:

City: State: Zip:

Occupation: Emergency Contact:

Employer: Emergency Contact Phone #:

Employer Location: Driver's License #:

Phone: Home Social Security #:

Work May we contact you at work? Y N

Mobile Spouse's Name (or parent's if minor):

Email Address: Spouse's Employer (or parent's if minor):

**Primary Dental Insurance**

Subscriber Name: Social Security #: DOB:

Employer: Insurance Company:

Insurance Co. Phone#: Group #:

Relation to patient:

**Secondary Dental Insurance**

Subscriber Name: Social Security #: DOB:

Employer: Insurance Company:

Insurance Co. Phone#: Group #:

Relation to patient:

**Insurance Authorization Statement (Please sign and date)**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred during dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signed: Date:

**If Patient is Under 18 Years of Age**

Responsible Party: Relation to Patient:

Street Address:

City: State: Zip:

Phone #: