Adult Registration & Health History Questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about your teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

By working together, we can strive to keep your natural teeth and thus improve your enjoyment of food, your appearance, your comfort and your health for the rest of your life.

DATE

PATIENT'S NAME DATE OF BIRTH

SOCIAL SECURITY NO. DRIVER'S LICENSE NO.

NAME (SPOUSE)

HOME ADDRESS

CITY STATE ZIP

HOME PHONE BUSINESS PHONE EXT. CELL PHONE

FOR WHAT COMPANY DO YOU WORK?

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN?

NAME OF INSURANCE COMPANY

IF MARRIED, OCCUPATION OF YOUR SPOUSE

FOR WHAT COMPANY DOES HE (SHE) WORK?

PHONE EXT. CELL PHONE

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT

NUMBER OF CHILDREN IN FAMILY FIRST NAME & AGES

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

THANK YOU