REGISTRATION & HEALTH HISTORY

William N. Langstaff, D.D.S., F.A.G.D.
A Professional Dental Corporation

DATE _____

PLEASE PRINT THE FOLLOWING PERSONAL INFORMATION

PATIENT'S NAME _____ LAST, FIRST, MIDDLE

O SINGLE
O MARRIED
O DIVORCED
O SEPARATED
O WIDOWED

RESIDENCE ADDRESS _____ STREET

CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE # _____ CELL # _____ BUSINESS TELEPHONE _____

PATIENT EMPLOYED BY _____ DATE OF BIRTH _____ CALIFORNIA DRIVERS LICENCE _____ AGE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ HOW LONG _____ SOCIAL SECURITY NUMBER _____

IN CASE OF AN EMERGENCY, WHOM SHOULD BE NOTIFIED? _____ TELEPHONE _____

PURPOSE OF THIS APPOINTMENT _____ REFERRED BY _____

IF PATIENT IS MARRIED, COMPLETE THIS PORTION

NAME OF SPOUSE _____ OCCUPATION _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ BUSINESS TELEPHONE _____

BUSINESS ADDRESS _____ CITY _____ ZIP CODE _____

IF PATIENT IS A MINOR (UNDER 18), COMPLETE THIS PORTION

PARENT OR RESPONSIBLE PARTY _____ OCCUPATION _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ BUSINESS TELEPHONE _____

BUSINESS ADDRESS _____ CITY _____ ZIP CODE _____

PLEASE COMPLETE THE FOLLOWING FINANCIAL INFORMATION

CO-PAY METHOD OF PAYMENT:

CREDIT CARD ☐ # _____ EXP. DATE _____ CHECK ☐ _____ CARE CREDIT ☐ _____

DENTAL INSURANCE, NAME OF COMPANY _____ NAME OF POLICY HOLDER _____ POLICY NUMBER _____

PHONE # _____ DOB POLICY HOLDER _____ SS# POLICY HOLDER _____

CONSENT

I HEREBY GRANT AUTHORITY TO THE DENTIST IN CHARGE OF THE PATIENT WHOSE NAME APPEARS ON THIS HEALTH HISTORY FORM TO ADMINISTER ANY TREATMENT AND TO ADMINISTER SUCH X-RAYS, ANESTHETICS OR SEDATIVES; AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THIS PATIENT.

I HAVE READ AND AGREE TO THE OFFICE FINANCIAL POLICY.

SIGNED _____ DATE _____

RELATIONSHIP IF PATIENT IS A MINOR OR PHYSICALLY OR MENTALLY HANDICAPPED: _____