SCOTT M. RUSS, DDS.
JEFFREY B. SENDER, DDS. PC.

82 West John Street
HICKSVILLE, NY 11801

PATIENT'S HISTORY INFORMATION

PLEASE PRINT Date:_____

PATIENT'S NAME: (FIRST) _____ (LAST) _____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP _____

SOCIAL SECURITY NUMBER: _____ LICENSE NUMBER: _____

TELEPHONE NUMBER (HOME): _____ (BUSINESS):_____

DATE OF BIRTH: _____ AGE: _____ CELL#: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED

EMAIL ADDRESS: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

SPOUSE'S FIRST NAME: _____

PATIENT'S OCCUPATION: _____

EMPLOYER: _____

PRIMARY INSURANCE COMPANY: _____

ID # _____ GROUP #: _____

SECONDARY INSURANCE COMPANY:_____

ID # _____ GROUP #: _____

REFERRED BY :(NAME OF RELATIVE, DOCTOR, FRIEND, ADVERTISEMENT, ETC.)

_____

HAVE WE SEEN ANY OTHER MEMBERS OF YOUR FAMILY? NAME & RELATIONSHIP

_____

RELATIVE WE MAY CONTACT INCASE OF EMERGENCY (LIVING WITH YOU)

_____

RELATIVE WE MAY CONTACT INCASE OF EMERGENCY (NOT LIVING WITH YOU)

NAME: _____ ADDRESS: _____

RELATIONSHIP:_____TELEPHONE#(HOME): _____ (WORK): _____

METHOD OF PAYMENT: ( ) CASH ( ) CHECK ( ) CHARGE

PAYMENT IS EXPECTED AT THE TIME OF VISIT UNLESS ARRANGED OTHERWISE IN ADVANCE