Personal History

Date:_____

Patient Name: Last:_____ First_____ Title_____

Home Address _____ City_____ State_____ Zip_____

Home Phone( )_____ Cell ( )_____ Work( )_____

Email_____ Social Security #_____

Date of Birth: Month _____Day_____ Year_____ Sex: F___ M____

Marital Status: Married__ Single__ Sep.__ Div.__ Wid.__ Spouse Name:_____

In Case of Emergency Contact: Name:_____ Phone:_____

Please Provide the following information if patient is under 18 years of age or has a legal guardian:

Father:_____ Contact#_____

Mother:_____ Contact #_____

Who will be responsible for payment? (If different from patient)

Name:_____ Relationship to patient_____ Contact#_____

Address:_____

Dental Insurance Information:

What is relationship to the policyholder? Self ___ Spouse ___ Child ___ Other___

Policyholder's Name:_____ SS#_____

Policyholder's Employer_____ Policy Holder Date of Birth_____

Name of Insurance Co. _____Ins. Company Phone#_____

Ins. Company Address:_____

Group#_____ ID#_____

Who recommended you to our office? Yellow Pages___ Internet___

Personal Referral____ Name :_____