Patient Registration and Health History

Patient Name (last, first, middle initial)	Birth Date	(Circle One) Single Married Divorced Separated Widowed

Spouse (first name, last if different)	If Child - Parent or Guardian	Patient Social Security #

Home Phone #	Business Phone #	Mobile Phone #	Best to Confirm Appt. (circle one)
Email Address			Home Business Mobile Email

Residence Address (please include city, state, zip)

Employer	Position	How Long Held

Insurance Policy Holder	Insured Social Security #	How will this account be paid?

Insurance Company Name and Claims Address

Who may we thank for this referral?	Are you having any current dental issues?

How do you feel about your smile?

Are you considering straightening or whitening your teeth?

What could we do to make your visit more pleasant?