PATIENT REGISTRATION & HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION

Date:

Name of Patient:

Spouse if applicable:

Mailing Address:

City: Prov: Postal Code:

Phone #:

Birthdate: Day/Month/Year

If filling out for a child:

Mom/Guardian's name & phone #:

Dad/Guardian's name & phone #:

REMINDERS & CONFIRMATIONS ARE DONE THROUGH EMAIL

Email:

Other family members who attend our office:

Referred to us by:

DENTAL INSURANCE

Policy Holder Name:

DOB:

Policy/Plan#:

Certificate/ID#:

SECONDARY INSURANCE

Policy Holder Name:

DOB:

Policy/Plan #:

Certificate/ID #:

Person to contact for Emergency:

Phone #:

Please fill out the health information on the back of this form