# PATIENT HISTORY

Date: _____

Name: _____
Last First Middle

Street Address: _____

City/State/Zip: _____

Home Phone: (___) _____Work Phone: (___) _____

Cell Phone: (___) _____ E-mail: _____

Patient Birthdate: _____ Sex: M ____ F ____

Patient Social Security: _____-_____-_____

Name of Spouse: _____

Closest Relative: _____Phone: (___) _____
(not living with you)

**Responsible Party**

**Name: _____ Phone #: (___) _____**

**Birthdate: _____ Social Security: _____-_____-_____**

**Address: _____**

_____

**REFFERAL SOURCE: _____**

**Check the following Co-payment method due the date of treatment:**

Cash ____ Check ___ Credit Card ___ Care Credit ___

Do you have dental insurance? Yes ___ No ___

Subscriber Name, Address & Phone:

_____

_____

_____

Subscriber Birthdate: _____ Social Security: _____-_____-_____

Subscriber Employer: _____

Insurance Company: _____

Group Number: _____