PERSONAL HISTORY

PATIENT NAME ______________________________ Date ______________
Last, First, Middle Initial

Social Security # ______________________________ Date of Birth ______________

Driver's License #: ______________________________ State: ______________

☐ Male ☐ Female ☐ Minor (child) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If married, maiden name: ______________ If divorced, previous name: ______________

Home Phone ______________ Work ______________ Ext. ______

Cell Phone ______________ Email ______________

Address: ____
Street Apartment #

____
City State Zip Code

How long at this address? ______________________________

Former Address:____
Street Apartment #

____
City State Zip Code

How long at that address? ______________________________

FINANCIALLY RESPONSIBLE PERSON: ☐ Patient (use information above) ☐ Parent ☐ Guardian

☐ Male ☐ Female ☐ Minor (child) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If married, maiden name: ______________ If divorced, previous name: ______________

Social Security # ______________________________ Date of Birth ______________

Driver's License #: ______________________________ State: ______________

Home Phone ______________ Work ______________ Ext. ______

Cell Phone ______________ Email ______________

Address: ____
Street Apartment #

____
City State Zip Code

How long at this address? ______________________________

Former Address:____
Street Apartment #

____
City State Zip Code

How long at that address? ______________________________

EMPLOYMENT INFORMATION The following is for: ☐ patient ☐ financially responsible person

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City State Zip Code

How long employed at the above employer?

EMERGENCY CONTACT

Spouse or Parent's Name (if minor patient):______________ Work/Day phone: ______________ Ext:______

EMERGENCY CONTACT: ______________________ Relationship: ______________
NAME (spouse, relative, friend…)

Home Phone ______________ Work ______________ Ext. ______

Cell Phone ______________ Email ______________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other______________________

Name of person or office referring you to our practice:______________________________