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Art of Dental Care
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REGISTRATION HISTORY

DATE: ___/ ___/ ____

PATIENT'S NAME _____

NAME OF SPOUSE _____

IF A CHILD, PARENT'S NAME _____

STREET ADDRESS _____

CITY _____STATE _____ ZIP _____

CELLPHONE# _____ HOME# _____

EMAIL ADDRESS _____

PATIENT EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____HOW LONG _____

SPOUSE EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE _____

WHO WILL PAY THIS ACCOUNT? _____

SOCIAL SECURITY NUMBER _____

SPOUSE'S SOCIAL SECURITY NUMBER _____
DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES?
YES _____ NO _____

IF SO, NAME OF COMPANY _____ POLICY# _____
IF INSURANCE COVERED, SOCIAL SECURITY # OF PERSON COVERED _____

DATE OF BIRTH OF THE PERSON COVERED _____

IF YOUR INSURANCE DOES NOT PAY THE BILL, WHO IS RESPONSIBLE FOR PAYING IT _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PURPOSE OF THIS APPOINTMENT _____