REGISTRATION / HEALTH HISTORY for Allegan Family Dentistry

DATE ______________________

REASON FOR APPOINTMENT

HOW MAY WE BE OF SERVICE TO YOU? ____

PATIENT INFORMATION

PATIENT'S NAME_____________________________________ Preferred "Nickname" (if applicable) ______________

NAME OF SPOUSE (IF APPLICABLE)____________________________________

IF A CHILD, PARENT'S NAME____

PATIENT'S ADDRESS_________________________________ CITY ______________ STATE _____ZIP _________

CELL PHONE_____________WORK PH____________ HOME PH ___________ EMAIL ______________________

CHECK IF DO ***NOT*** WANT TEXT MESSAGE APPOINTMENT CONFIRMATIONS____(IF UNCHECKED WE WILL ASSUME OK)

MARITAL STATUS__________ DATE OF BIRTH _____________ AGE _______

PATIENT'S SOCIAL SECURITY #________________________ SEX ______________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

ACCOUNT GUARANTOR INFORMATION

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? ____

NAME OF EMPLOYER_________________________________ CITY/STATE/ZIP ______________________________

DO YOU HAVE DENTAL INSURANCE? YES_____ NO______ ***IF YES****, PLEASE COMPLETE THE FOLLOWING ALSO:*

NAME OF DENTAL INSURANCE CARRIER__________________________________ GROUP #_________________

IF YOU HAVE DENTAL INSURANCE THROUGH SOMEONE OTHER THAN THE PATIENT:

NAME OF EMPLOYEE/SUBSCRIBER__________________ SUBSCRIBER RELATIONSHIP TO PATIENT______________

SUBSCRIBER DATE OF BIRTH ___________________ SUBSCRIBER SOCIAL SECURITY # _________________________

HOME ADDRESS(ONLY IF DIFFERENT THAN PATIENT'S)__________________ CITY/STATE/ZIP ____________________

IF YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE, PLEASE COMPLETE THE FOLLOWING:

EMPLOYEE/SUBSCRIBER NAME__________________ SUBSCRIBER BIRTHDATE _________ EMPLOYER______________

SUBSCRIBER RELATIONSHIP TO PATIENT ______________ SUBSCRIBER SOCIAL SECURITY #______________________

SUBSCRIBER ADDRESS____________________________________ CITY/STATE/ZIP ____________________________

OVER PLEASE