

# PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

**Medical Alert**

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.  
(PLEASE PRINT)

Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Email \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Sex:  Male  Female Age \_\_\_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_

Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Social Security # \_\_\_\_\_

**Person Responsible For Account**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Hm# ( ) \_\_\_\_\_ DL# \_\_\_\_\_

Employer: \_\_\_\_\_

Wk# ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ SS# \_\_\_\_\_

### *Dental Insurance Primary Carrier*

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### *Dental Insurance Secondary Carrier*

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Tel. \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Medical History

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Address \_\_\_\_\_ Tel. \_\_\_\_\_

