PREMIER DENTAL

Dental Registration and Health History

Our goal at Premier Dental is to work with you to create a healthy and attractive smile you deserve. It's all about you! Please complete this form so that we can better know how to provide you with the best dental care.

Personal History

Patient's Name: _____ Date:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M / F Birth Date: _____Age: _____ SS#: _____

Cell Phone: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____

Whom may we thank for referring you? _____

If the person responsible for this patient's account is different from the patient, or if this patient is a minor, the responsible party must fill out the section below.

Name of Responsible Party: _____ Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M / F Birth Date: _____ Age: _____ SS#: _____

Please Circle One: Single Married Widowed Separated Divorced

Cell Phone: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____