

## PATIENT REGISTRATION & HEALTH HISTORY FORM

Please complete the following confidential patient information so that we may make your visit pleasant and comfortable.

- How Did You Hear About Our Office?**
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Family/Friend (Name: _____)      | <input type="checkbox"/> Mailer                             | <input type="checkbox"/> Referral Brochure (If Yes, From Whom? _____) |
| <input type="checkbox"/> Building Sign/Drive-By           | <input type="checkbox"/> Website/Web Search Engine          | <input type="checkbox"/> Amherst Bee Advertisement                    |
| <input type="checkbox"/> Verizon Superpages (Erie County) | <input type="checkbox"/> Verizon Superpages (Williamsville) | <input type="checkbox"/> The Talking Phone Book                       |
| <input type="checkbox"/> Other (Please Explain: _____)    |   |   |

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Street Address: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Employer: \_\_\_\_\_ Emergency Contact Phone #: \_\_\_\_\_

Employer Location: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work \_\_\_\_\_ May we contact you at work? Y N

Mobile \_\_\_\_\_ Spouse's Name (or parent's if minor): \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouse's Employer (or parent's if minor): \_\_\_\_\_

**Primary Dental Insurance**

Subscriber Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_ Group #: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

**Secondary Dental Insurance**

Subscriber Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_ Group #: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

**Insurance Authorization Statement (Please sign and date)**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred during dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**If Patient is Under 18 Years of Age**

Responsible Party: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Phone #: \_\_\_\_\_