

SMITH DENTAL CENTER PATIENT HEALTH HISTORY FORM

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(preferred name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer name/ number			Email Address		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other							
Other family members seen here:							

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for Account:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:		Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Insurance ID
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Smith Dental Center. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Smith Dental Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	