

PATIENT MEDICAL HISTORY

Patient's Name:

Date of Birth:

Today's Date:

Mailing Address:

City, State, Zip:

Home Phone:

Cell Phone:

Emergency Contact:

Emergency Contact Phone:

Your E-mail:

General Dentist:

Primary Care Physician:

Do You Have Dental Insurance **Yes** **No**

Primary Dental Insurance Company:

Subscriber's Employer:

Subscriber:

Name:

Subscriber ID/SSN#:

Subscribers DOB:

Self **Other**

Secondary Dental Insurance Company:

Subscribers Employer:

Subscriber:

Name:

Subscriber ID/SSN#:

Subscribers DOB:

Self **Other**

Notes: