GRAND HAVEN FAMILY DENTISTRY

REGISTRATION/HEALTH HISTORY_____

Date:_____
What is the reason for your visit today?_____
Name:_____ Marital Status: S M W D SEP
Address:_____ Zip Code:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ E-mail:_____
Social Security No.:_____ Drivers License No.:_____
Birthdate:_____ Place of employment(or school):_____
Has any member of your family been treated by our office?:_____
Whom were you referred by?:_____

FAMILY INFORMATION_____

Husband / Father Wife / Mother

Name:_____-_____
Address:_____-_____
Telephone:_____-_____

DENTAL INSURANCE INFORMATION_____

Primary Secondary

Subscriber's name:_____-_____
Birthdate: _____-_____
Social Security No.:_____-_____
Employer:_____-_____
Dental Ins. Co.:_____-_____
Group/Policy No.:_____-_____

EMERGENCY INFORMATION_____

Person to contact in case of an emergency-outside of household:
Name:_____
Address:_____Telephone:_____