

# Patient Registration and Health History

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### About You

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

E-mail Address: \_\_\_\_\_

Name: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_

Employer: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where and when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_

### Spouse Information

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS# \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

Person Responsible for Account: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

### Insurance

#### Primary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

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

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured ID #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Secondary Insurance

Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

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

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured ID #: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Cell# (\_\_\_\_) \_\_\_\_\_

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

### Medical History

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Date of last Visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please Explain: \_\_\_\_\_

