GRAHAM
FAMILY DENTAL & SPA

# DENTAL REGISTRATION AND HISTORY

## Patient Information

Patient: _____
Address: _____
_____
City State Zip
E-Mail:_____
Sex: ☐M ☐F Age: _____ Birthdate: _____
Height: _____ Weight: _____
☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient SS#: _____
Occupation: _____
Employer: _____
Employer Address: _____
_____
City State Zip
Employer Phone: _____
Spouse's Name: _____
Birthdate: _____ SS#:_____
Occupation:_____
Spouse's Employer: _____
Whom may we thank for referring you?
_____

## Dental Insurance

Who is responsible for account:_____
Relationship to Patient:_____
Insurance Co:_____
Group#:_____
Is patient covered by additional insurance? ☐Yes ☐No
Subscriber's Name:_____
Birthdate:_____ SS#:_____
Relationship to Patient:_____
Insurance Co:_____

ASSIGNMENT AND RELEASE I, the undersigned certify that I(or my dependent) have insurance coverage with _____ and assign directly to Dr. Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party
_____
Relationship Date

## Phone Numbers and HIPAA Release

Home: _____ Cell:_____ Work:_____ Ext:_____
Best time to reach you: _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)
Name: _____ Relationship:_____
Home Phone: _____ Cell Phone:_____ Work Phone:_____

Whom may we release Health and Account information to: _____

## Medications

List medications you are currently taking:
_____
_____
_____
_____

If additional room needed please write on back of page.

Pharmacy Name:_____

Phone: _____

## Allergies

☐ Aspirin ☐ Local Anesthetic ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Latex
☐ Codeine ☐ Sulfa ☐ Iodine
☐ Other:
_____
_____

Reason for today's Visit:
_____
_____