# MEDICAL HISTORY RECORD

Today's Date: _____ Dentist Name: _____ Physician Name: _____

## Patient Information

Name: _____ (Last / First / M.I.) S.S.#: _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone: _____

_____ (City / State / Zip) Cell Phone: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Spouse/ Partner Name: _____

## Person Responsible for Payment

☐ *Same as above (If so, leave this section blank)*

Name: _____ (Last / First / M.I.) S.S.#: _____

Email: _____ Date of Birth: _____

Address: _____ (Number and Street) Home Phone: _____

_____ (City / State / Zip) Cell Phone: _____

Employer: _____ Work Phone: _____

Relationship to Patient: _____

## Dental Insurance

| | Primary Dental Insurance | Secondary Dental Insurance (if applicable) |
|---|---|---|
| Insured Name: | _____ (Last / First / M.I.) | _____ (Last / First / M.I.) |
| Insured Birthdate: | | |
| Employer: | | |
| Group # / ID #: | _____ / _____ (Group # / ID #) | _____ / _____ (Group # / ID #) |
| Insurance Name: | | |
| Insurance Address: | | |