

**INFORMATION REQUIRED FOR CASE HISTORY RECORD**  
 The complete confidential record is important for our records and your health.  
**PLEASE PRINT the following information.**

**Circle one:** → Male Female

Mr. ↓  
 Mrs. Dr. Patient \_\_\_\_\_ Date \_\_\_\_\_  
 Miss Child last first middle

Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
street apt. # city state zip

Circle one: Single Married Separated Divorced Widowed Race \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
street suite # city state zip

**PERSON financially responsible** \_\_\_\_\_ relationship \_\_\_\_\_

**If patient is not responsible, or if patient is married, complete this section**

Parent/Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Mailing Address \_\_\_\_\_ home phone \_\_\_\_\_  
street city state zip

business phone \_\_\_\_\_

Spouse's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Employer \_\_\_\_\_ business phone \_\_\_\_\_

Business Address \_\_\_\_\_ zip \_\_\_\_\_  
street city state

Who is your General Dentist? \_\_\_\_\_  
 Who is your Orthodontist? \_\_\_\_\_  
 Who referred you to this office? \_\_\_\_\_

<b>P A T I E N T S</b>	Do you have dental insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		Medical insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	<b>Insurance Company Name</b>		<b>Policyholder (Subscriber)</b>		
			<b>Policy Number or Certificate Number</b>		
	1.	<input type="checkbox"/> Dental <input type="checkbox"/> Med	_____	_____	
	2.	<input type="checkbox"/> Dental <input type="checkbox"/> Med	_____	_____	
	3.	<input type="checkbox"/> Dental <input type="checkbox"/> Med	_____	_____	
	Name of nearest relative not living with you _____				
	Relationship _____		Phone _____		
	Address _____ <small>street city state zip</small>				

Have you or any member of your family ever been a patient in this office before? Yes  No