



LOUDOUN SMILE CENTER

HEALTH HISTORY & REGISTRATION

DATE _____

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

Soc. Sec. # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____ Birthdate _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

**Primary
Insurance**

If you have additional dental insurance coverage, complete this for the secondary carrier

Insured's Name _____ Birthdate _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

**Secondary
Insurance**

Thank you for allowing us the opportunity to serve your dental needs!