DENTAL smiles
AT PURCELLVILLE GATEWAY

# 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)

**Primary Insurance**

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

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

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

**Secondary Insurance**

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

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

In order to comply with the Occupational Safety & Health Administration (OSHA Bloodborne Pathogen Regulation and Virginia State Law, we are requesting your consent to submit to testing of your blood for bloodborne pathogens (hepatitis B, hepatitis C & HIV) if an exposure occurs (needlestick injury, blood splatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential. Date _____ Signature _____