DOWNEY
DENTAL HEALTH

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Patient History Information

Patient_____ Birthday_____

Married _____ Single _____ Widowed _____ Divorced _____Separated_____

Home Address_____

Home Phone _____ Cell Phone_____

City_____ State_____ Zip Code_____

Email Address_____

If Patient is a Minor, Name of Responsible Party_____

Employer or School Name_____

City_____Phone_____

Business Address_____

Occupation_____ Phone_____

Social Security Number _____ Driver's License_____

Name of Spouse_____ Spouse's Birthday_____

Spouse's Social Security Number_____Driver's License_____

Patient Referred to Doctor By_____

In Case of Emergency, Please Notify: _____

Relationship to Patient_____Phone_____

Dental Insurance _____ Yes _____ No If yes, please continue below.

Dental Insurance Information

Dental Insurance Policy Holder_____

Holder's SSN: _____ Gender _____

Insurance Company _____ Group#_____

Policy #_____ Holder's Driver's License # and State_____

Holder's Employer:_____
Company

_____
Street City State Zip

Secondary Insurance Policy Holder_____

Holder's SSN: _____ Gender _____

Insurance Company _____ Group#_____

Policy #_____ Holder's Driver's License # and State_____

Holder's Employer:_____
Company

_____
Street City State Zip