SOCIAL HISTORY

DATE: _____

PATIENT NAME: _____ M☐ F☐

ADDRESS: _____

_____

EMAIL: _____

EMPLOYER: _____

SPOUSE NAME: _____

SPOUSE EMPLOYED BY: _____

EMERGENCY NAME & PHONE: _____

_____

PREVIOUS DENTIST: _____

DATE LAST SEEN: _____

PHYSICIAN'S NAME: _____

DENTAL INSURANCE CO. _____

POLICY HOLDERS SOC. SEC. # _____

DATE OF BIRTH: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

SS#: _____

PLEASE COMPLETE FOR MINORS OR STUDENTS

SCHOOL: _____

PARENT'S NAME: _____

MOM'S OCCUPATION: _____

MOM'S WORK #: _____

DAD'S OCCUPATION: _____

DAD'S WORK #: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DOB: _____

PAYMENT METHOD: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ FLEX

PERSON RESPONSIBLE FOR ACCOUNT: _____