ABOUT YOU:

Date: _____

Name: _____ ○ Male ○ Female

Address: _____

_____

E-mail Address: _____ Social Security # _____

Home # ( ) _____ Pager/ Cell # ( ) _____

Work # ( ) _____ ext: _____ May we call there? _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Whom may we thank for referring you? _____

Present Dentist: Name _____ How long? _____

Address _____ Phone # _____

IF THIS APPOINTMENT IS FOR YOUR CHILD OR MINOR:

Date: _____

Name: _____ ○ Male ○ Female

Address: _____

_____

Social Security # _____ Home # ( ) _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Whom may we thank for referring? _____

Present Dentist: Name _____ How long? _____

Address _____ Phone # _____

PARENT/GUARDIAN INFORMATION:

Who is responsible for this account: _____

Name: _____ Relationship to Patient _____

Address: _____

Home # ( ) _____ Pager/ Cell # ( ) _____

Work # ( ) _____ ext: _____ May we call there? _____

I / we parent or guardian of _____ hereby permits Barry P Levin,DMD, PC to treat our child/minor. Signature _____Date _____

I**NSURANCE INFORMATION:** **Primary Insurance**

Name of insured_____Birthdate _____ Relationship _____

Social Security # _____Employer _____

Ins.Co.Name/ Address: _____ ** please provide copy of card/form**

_____ Phone # _____

Policy # _____ Group # _____

Secondary Insurance

Name of insured_____ Birthdate _____ Relationship _____

Social Security # _____Employer _____

Ins.Co.Name/ Address: _____ ** please provide copy of card/form**

_____ Phone # _____

Policy # _____ Group # _____

PATIENT REGISTRATION HISTORY