Bethany J Geyman DDS

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Health History and Registration

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* _____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

Emergency contact- Name, Relationship, Phone#: *

_____

_____

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Referred to us by:

Referral Name: _____

Reason for today's visit?

_____

_____

The date of your last dental visit? _____

Previous dentist: _____

Reason for leaving previous dentist:

_____

_____