Comprehensive Dental Care,
1901 Pennsylvania Ave., N.W.
Suite 905
Washington, DC 20006

Patient Registration and Medical History

Patient's Name: _____

Sex: _____ DOB: _____ Age: _____ S.S. #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Marital Status: _____

Spouse Name: _____ S.S. #: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Physician Name: _____ Phone #: _____

Whom may we thank for referring you to us? _____

_____

Patient's Authorization: I Certify that all information is correct, I authorize the release of my medical records for insurance or other relevant purpose.

Signature: _____ Date: _____