

REGISTRATION & MEDICAL HISTORY

45005 W. Pontiac Trail, Novi, MI 48377

NoviFamilyDentist.com * Leslie Taub, D.D.S.

248-669-1040 * E-mail office@novifamilydentist.com

As required by law, our office adheres to policies to protect the privacy of information you give to us or that we maintain. This information is strictly confidential and will not be released without your written permission.

PATIENT INFORMATION:

Name _____ Sex _____ Date of Birth _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____ Marital Status _____
 Phone# _____ Cell # _____ E-mail _____
 Driver's License # _____ Social Security # _____
 Employer _____ Phone # _____
 Business Address _____ City _____ Zip _____
 Insurance Co _____ Group# _____ Policy# _____

SPOUSE INFORMATION:

Name _____ Date of Birth _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone# _____ Cell # _____ E-mail _____
 Driver's License # _____ Social Security # _____
 Employer _____ Phone # _____
 Business Address _____ City _____ Zip _____
 Insurance Co _____ Group # _____ Policy # _____

IN CASE OF EMERGENCY whom should we notify (living outside the home)?

Name _____ Phone# _____

Whom may we thank for referring you? _____

If not by referral, how did you hear about us? _____

PURPOSE OF THIS APPOINTMENT _____

Date of last dental appointment _____

Date of last medical examination _____

Are you currently under the care of a physician? Yes _____ No _____

If so, what condition is being treated? _____

Name of your physician _____ Phone _____

Address _____ City _____

May we request your health records, if needed? Yes _____ No _____

If you have dental insurance: I authorize payment of dental benefits to Leslie Taub, D.D.S. for services rendered and authorize release of any dental information necessary to process my claim. I am responsible for all costs not covered by insurance, after discounts for insurance participation.

Patient's signature _____ **Date** _____

