Robert J. Asp, DDS
& Associates

Live Life Smiling!

Updated Registration and History

Contact Information

Today's Date ________________________

Patient Name (Last, First, MI) ________________

____

Address (☐ Unchanged) ________________

____

City ________________________________

State ________________ Zip ____________

Home (_____) ________________________

Work (_____) ________________________

Cell Phone (_____)____________________

Employer (☐ Unchanged) ________________

Occupation __________________________

Employer Address ____________________

____

Marital Status (☐ Unchanged)______________

Spouse's Name________________________

Insurance Information

Has your insurance information changed? Yes/No

If so, please fill out the information below:

Company Name ________________________

Address ________________________________

City ________________________________

State ________________ Zip ____________

Phone (_____) ________________________

Insured's ID# ________________________

Group # ____________________________

Insured's Name________________________

Relation ______________ Birthdate __________

Insured's Employer______________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Signature ____________________________

Medical History

What medications are you currently taking? *Please include any over-the-counter drugs*. ________________

____

Please list any **new** allergies, diseases, medical conditions, or procedures (include dates when possible): ________

____

____

Physician's Name ______________________ Phone (_____) ________________

Emergency Contact (☐ Unchanged) ______________ Phone (_____) ________________

Relation ______________________________ Cell Phone (_____)________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.
This office may also leave messages on my voice mail, answering machine, or with a family member in regards to my or my family's appointments and necessary information.

Please Print Name______________________________ Signature______________________