Dr. Bimal S. Mehta
Cosmetic and General Dentistry

Patient Registration and Medical History
Please complete the following Confidential Information

Date
Name
Spouse
Address
City State Zip
Home Phone # Work Phone # Cell Phone #
Birth Date Age
☐ Married ☐ Single ☐ Divorced ☐ Student
SS# Drivers License #

DENTAL INSURANCE- Primary Carrier
Insurance Company
Employee
Group Number
Employee SS #
DENTAL INSURANCE– Secondary Carrier
Insurance Company
Employee
Group Number
Employee SS #

Account Information **Person Financially Responsible for Account**
Your name
Occupation
Employer
Business Address
City State Zip
Spouse's Name
Occupation
Employer
Business Address
City State Zip
Business Phone

GETTING TO KNOW YOU
Is another member of your family or relative a patient at this office? ☐ YES ☐ NO THEIR NAME:
Referred to us by:
Person to contact for Emergency:
Phone Number
Address
City State Zip

EMAIL