



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 _____