

THERESE L O'BRIEN, DDS

2409 L Street, Suite 2
Sacramento, CA 95816

Please help us get to know you by completing the following confidential health history and information.

Name _____ Age _____
Address _____ M/F _____
City _____ State _____ Zip _____
I prefer to be called _____
Home () _____
Work () _____
Cell () _____
Birthday _____ / _____ / _____
 MONTH DAY YEAR
If patient is a minor, please complete:
Parent's name _____
Address _____

H () _____ W () _____

Employer Information
Company name _____
Address _____

Work () _____ ext. _____
Occupation _____
Emergency Contact
Name _____
Address _____

H () _____ W () _____
Relationship to patient _____

Primary Insurance
Ins. Co. Name _____
Address _____
Phone () _____
Insured's name _____
DOB _____
SS# _____
Secondary Insurance
Ins. Co. Name _____
Address _____
Phone () _____
Insured's name _____
DOB _____
SS# _____

About You
Marital Status _____
Do you have children? Yes No
If yes, how many? _____
Do you have pets? Yes No
If yes, what kind? _____

What type of hobbies/activities do you enjoy? _____

Driver's Lic. # _____
Whom may we thank for referring you?

When did they refer you? _____