TIME: 8:27 am date 12/7/2004

PATIENT REGISTRATION

Id:	Chart ID:		
First Name:		Last Name:	
Patient is: O Policy Holder	O Responsible Party		
Responsible Party (if someon	ne other than the patient)		
First Name:		Last Name:	
Address:		Address 2:	
City, State, Zip:		Pager:	
Home Phone:	Work P	Phone: Ext: Cellular:	
Birth Date:	Soc. Se	ec: Drivers Lic:	
O Responsible Party is also	a Policy Holder for Patient	OPrimary Insurance Policy Holder OSecondary Insurance Policy Holder	
Patient Information			
Address:		Address 2:	
		Zip: Pager:	
		Phone: Ext: Cellular:	
	_	l Status: OMarried OSingle ODivorced Separated OWidowed	
Birth Date:	Age:	Soc. Sec: Drivers Lic:	
E-Mail:		I would like to receive correspondences via e-mail.	
Section 2		Section 3	
Employment Status:	Full TimePart TimeRetired	Cell #:	
Student Status:	Full TimePart Time	Emergency Contact:	
Medicaid ID:	Pref. Dentist:	Contact #:	_
Employer ID:	Pref. Pharmacy: _		
Carrier ID:	Pref. Hyg.:		
Primary Insurance Information	on		
Name of Insured:		Relationship to Patient: OSelf OSpouse OChild OOther	
Insured Soc. Sec:		Insured Birth Date:	
Employer:			
Address 2:		Address 2:	
Rem. Benefits:		Rem. Deduct: .00	
Secondary Insurance Informa	ation		
Name of Insured:		Relationship to Patient: OSelf OSpouse OChild OOther	
Insured Soc. Sec:			
Employer:			
Rem. Benefits:		Rem. Deduct: .00	

Today's Family Dentistry MEDICAL HISTORY

O AIDS/HIV Positive O Chest Pains O Frequent Headaches O Irregular Heartbeat O Scarlet Fever O Alzheimer's Disease O Cold Sores/Fever Blister O Genital Herpes O Kidney Problems O Shingles O Anaphylaxis O Congenital Heart Disorder O Glaucoma O Leukemia O Sickle Cell Disease O Anaphylaxis O Convulsions O Hay Fever O Liver Disease O Sinus Trouble O Angina O Cortisone Medicine O Heart Attach/Failure O Low Blood Pressure O Spina Bifida O Arthritis/Gout O Diabetes O Heart Murmur O Lung Disease O Stomach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Stroke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O Asthma O Emphysema O Hemophilia O Psychiatric Care O Tonsillitis O Blood Disease O Epilepsy or Seizures O Hepatitis A O Psychiatric Care O Tonsillitis O Broad Transfusion O Excessive Bleeding O Hepatitis B or C O Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Thirst O Herpes O Recent Weight Loss O Tumors or Growths O Bruise Easily O Fainting Spells/Dizziness O High Blood Pressure Renal Dialysis O Ulcers O Cancer O Frequent Cough O Hives or Rash O Rheumatism O Yellow Jaundice Have you ever had any serious illness not listed above? OYes ONo If yes, please explain: O	PATIENT NAME	B				_ Birth	Date		
Have you ever been hospitalized or had a major operation: OYes ONo If yes, please explain: Have you taking any medications, pills, or drugs? OYes ONo If yes, please explain: Do you take, or have you taken, Phen-fen or Redux? OYes ONo Do you use controlled substances: OYes ONo Do you use Tobacco? OYes ONO Do you use Tobacco? OYes ONO Do you use controlled substances: OYes ONO Do you use controlled you use c	medication that you may be	•	•						
Have you ever been hospitalized or had a major operation: OYes ONo If yes, please explain: Have you taking any medications, pills, or drugs? OYes ONo If yes, please explain: Do you take, or have you taken, Phen-fero Redux? OYes ONo Do you use controlled substances: OYes ONo Do you use Tobacco? OYes ONo Do you use Tobacco? OYes ONo Do you use controlled substances: OYes ONo Officer of the young the properties of the young taken of the you	Are you	under a physician's care now:	Oyes	ONo	If yes, pl	ease explain:			
Have you taking any medications, pills, or drugs? O'Yes ONo Are you take, or have you taken. Phen-Fen or Redux? O'Yes ONo Are you take, or have you taken. Phen-Fen or Redux? O'Yes ONo Do you use Tobacco? O'Yes ONo Do you use Controlled substances: O'Yes ONo Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O'Other If yes, please explain: Do you have, or have you had, any of the following: O'Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O'Other If yes, please explain: Do you have, or have you had, any of the following: O'AlbS'HIV Positive O Chest Pains O Frequent Headaches O Irregular Heartbeat O Scarlet Fever O Albeimer's Disease O Code Sores/Fever Blister O Gential Herps: O Kidney Problems O Shingles O'Anemia O Convulsions O Hay Fever O Later Disease O Shingles O'Angina O Cortisone Medicine O Heart Attach/Failure O Low Blood Pressure O Shina Brida O'Artificial Heart Valve O Diabetes O Heart Murruur O Low Blood Pressure O Storach/Incisational Disease O'Artificial Heart Valve O Diabetes O Heart Murruur O Low Blood Pressure O Storach/Incisational Disease O'Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O'Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O'Broud Transfusion O Excessive Blisted O Hepatits B or C Read Indianty Transments O Taberculosis O Recent Weight Loss O Truncs or Growths O'Broud Disease O Epilepsy or Seizures O Hepatits B or C Read Indianty Transments O Taberculosis O Heaven Read O Pressure O Tobal Disease O Tobal				_					
Are you taking any medications, pills, or drugs? O'Yes O'No Are you take, or have you taken, Phen-Fen or Redux? O'Yes O'No Do you use Tobacco? O'Yes O'No Do you use controlled substances: O'Yes O'No Traking oral contraceptives: Are you allergic to any of the following: O Aspirin O Pencicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other If yes, please explain: Do you have, or have you had, any of the following: O AlbS-HIV Positive O Chest Pains O Frequent Headaches O Irregular Heartbeat O Scarlet Fever O Alabeimer's Disease O Cold Soves/Fever Blister O Gential Herpes O Kidney Problems O Shingles O Anephia O Convulsions Hay Fever O Liver Disease O Sinus Trouble O Artificial Heart Valve O Diabetes O Heart Attach/Valture O Low Blood Pressure O Stimach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Attach/Valture O Low Blood Pressure O Storach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart ProblePoleses O Storach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Problepose O Stroke O Artificial Heart Valve O Drug Addiction O Heart ProblePoleses O Pain in Jaw Joints S welling of Limbs O Asthma O Emphysema O Hemophilia O Parathyroid Disease O Thyroid Disease O Blood Transfusion O Excessive Bledning O Heapattis B or C Papelin Bird O Recand Weight Loss O Broud Disease O Epilepsy or Seizures O Hepattis B or C Papelin Dispasse O Thyroid Disease O Enruise Easily O Frequent Dismance O Hepattis B or C Papelin Dispasse O Thyroid Disease O Chemotherapy O Frequent Dismance O Hepattis B or C Papelin Dispasse O Thyroid Disease O Chemotherapy O Frequent Dismance O Hepattis B or C Papelin Dispasse O Thyroid Disease O Thyroid Diseas			_						
Do you take, or have you taken, Phen-Fen or Redux? Oyes ONo Are you on a special diet? Oyes ONo Do you use Tobacco? Oyes ONo Do you use Controlled substances: Oyes ONo Do you have, or have you had, any of the following: Other If yes, please explain: Do you have, or have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on have you had, any of the following: O Alzhing on had, any of the following: O Alzhing on had, any of the following: O Alzhing on had, any of the following: O Convolutions O Conv			_	_					
Are you on a special dier? Oyes ONo Do you use Tobacco? Oyes ONo Do you use Controlled substances: Oyes ONo The guard Trying to get pregnant? ONursing: OTaking oral contraceptives: OTaking oral contraceptives: OTaking oral contraceptives: OTaking oral contraceptives: OTaking oral contraceptives: OTaking oral contraceptives: OTaking	Are you taking any medications, pills, or drugs?		OYes	ONo	If yes, pl	ease explain:			
Do you use Controlled substances: Ore ONO Do you use controlled substances: Ore ONO Do you use controlled substances: Ore ONO Taking oral contraceptives: Are you allergic to any of the following: Other If yes, please explain: Do you have, or have you had, any of the following: Other If yes, please explain: Do you have, or have you had, any of the following: Other If yes, please explain: Do you have, or have you had, any of the following: Other Pains Orequent Headaches Oreginal Heart Disorder Organical Organical Heart Disorder Organical Organical Heart Disorder Organical Heart Disorder Organical Heart Disorder Organical Heart Disorder Organical Organical Heart Disorder Organical Heart Disorder Organical Heart Disorder Organical Organical Organical Heart Disorder Organical Organical Heart Disorder Organ	Do you take, or have y	ou taken, Phen-Fen or Redux?	Oyes	ONo					
Do you use controlled substances: OYes ONo Oracing: ONuning: Oracing oral contraceptives: Are you allergic to any of the following: Ospiral Openicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics Other If yes, please explain: Do you have, or have you had, any of the following: Other Other Office O Codeine O Acrylic O Metal O Latex O Local Anesthetics O there If yes, please explain: Do you have, or have you had, any of the following: O AlDASHIV Positive O Chest Pains O Frequent Headaches O Irregular Heartheat O Scarlet Fever O Alzheimer's Disease O Cold Sores/Fever Blister O Genital Herpes O Kidney Problems O Shingles O Anaphylaxis O Congenital Heart Disorder O Glaucoma O Loukemia O Sickle Cell Disease O Anaphylaxis O Congenital Heart Disorder O Glaucoma O Loukemia O Sickle Cell Disease O Anaphylaxis O Contisone Medicine Heart Attach/Failure O Low Blood Pressure O Spina Bifida O Arthritis/Gout O Diabetes O Heart Murruur O Long Disease O Stormach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Stroke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Paint in Jusy Joints O Swelling of Limbs O Asthma O Emphysema O Hemophilia O Parathyroid Disease O Thyroid Disease O Blood Disease O Epilepsy or Scizures O Hepatitis A O Psychiatric Care O Tonsillitis O Broating Problem O Excessive Bleeding O Hepatitis B or C Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Bleeding O Hepatitis B or C Radiation Treatments O Tuberculosis O Tumors or Growths O Bruste Easily O Fainting Spells/Dizziness O High Blood Pressure O Renal Dialysis O Ulcers O Tensor or Growths O Bruste Easily O Fainting Spells/Dizziness O High Blood Pressure O Renal Dialysis O Ulcers O Tensor or Growths O		Are you on a special diet?	Oyes	ONo					
Are you allergic to any of the following: O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other If yes, please explain: Do you have, or have you had, any of the following: O AIDS/HIV Positive O Chest Pains O Frequent Headaches O Irregular Heartbeat O Scarlet Fever O Alzheimer's Discase O Cold Sores/Fever Blister O Genital Herpes O Kidney Problems O Shingles Anaphylaxis O Congenital Heart Disorder'O Glaucoma Leukemia O Sickle Cell Disease O Anemia O Convulsions O Hay Fever O Lever Disease O Sinus Trouble Angina O Cortisone Medicine O Heart Murmur O Lung Disease O Storoke O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Storoke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O Blood Disease O Epilepsy or Scizures O Hepatitis A O Psychiatric Care O Tonsilltis O Brouker O Excessive Bleeding O Hepatitis B or C O Raddiation Treatments O Tuberculosis O Brouker O Frequent Diarrhee O Hives or Rash O Remember O Frequent Diarrhee O Hives or Rash O Remember O Frequent Diarrhee O Hypoglycemia O Remains O Yes O No If yes, please explain: Comments: HOW DID YOU HEAR ABOUT US? WHO REFERRED YOU? Date Signed (Employee'authorized patient) Date Signed (Employee'authorized patient) Date Signed (Employee'authorized patient) Date Signed (Employee'authorized patient) Date Signed (Employee'authorized patient) Date To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Do you use Tobacco?		Oyes	ONo	o I				
Other If yes, please explain: Other	Do	you use controlled substances:	Oyes	ONo				it? ONursing:	
Other If yes, please explain: Do you have, or have you had, any of the following: AIDS/HIV Positive	Are you allergic to any of th	ne following:							
Do you have, or have you had, any of the following: O AIDS/HIV Positive O Chest Pains O Frequent Headaches O Irregular Heartbeat O Scarlet Fever O AIzheimer's Disease O Cold Sores/Fever Blister O Genital Herpes O Kidney Problems O Shingles O Anaphylaxis O Congenital Heart Disorder O Glaucoma O Leukemia O Sickle Cell Disease O Anemia O Convulsions O Hay Fever O Liver Disease O Sinus Trouble Anemia O Cortisone Medicine O Heart Attach/Failure O Low Blood Pressure O Spina Bifida O Arthritis/Gout O Diabetes O Heart Murmur O Lung Disease O Stomach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Stroke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O Asthma O Emphysema O Hemophilia O Parathyroid Disease O Hoppinia O Parathyroid Disease O Hepatitis A O Psychiatric Care O Tonsillitis O Blood Disease O Fpilepsy or Scizures O Hepatitis B or C O Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Bleeding Hepatitis B or C O Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Thirst O Herpes O Recent Weight Loss O Tumors or Growths O Bruise Easily O Fainting Spells/Dizziness O High Blood Pressure O Renal Dialysis O Ulcers O'Chemotherapy O Frequent Cough O Hives or Rash O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Tolarhea Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Chemotherapy O Frequent Diarhea O Hypoglycemia O Rheumatic Fever O Venereal Disease O'Che	O Aspirin O Peni	icillin O Codeine	O Acry	·lic	O Meta	ı O L	atex	O Local Anesthetics	
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O Anemia O Convulsions O Hay Fever O Liver Disease O Sinus Trouble O Angina O Cortisone Medicine O Heart Attach/Failure O Low Blood Pressure O Spina Bifida O Arthritis/Gout O Diabetes O Heart Murmur O Lung Disease O Stomach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Stroke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O Asthma O Emphysema O Hemophilia O Parathyroid Disease O Thyroid Disease O Blood Disease O Epilepsy or Seizures O Hepatitis A O Psychiatric Care O Tonsillitis O Blood Transfusion O Excessive Bleeding O Hepatitis B or C O Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Thirst O Herpes O Recent Weight Loss O Tumors or Growths O Bruise Easily O Fainting Spells/Dizziness O High Blood Pressure O Renal Dialysis O Ulcers O Cancer O Frequent Cough O Hives or Rash O Rheumatic Fever O Venereal Disease O Chemotherapy O Frequent Diarrhea O Hypoglycemia O Rheumatism O Yellow Jaundice Have you ever had any serious illness not listed above? O Yes ONo If yes, please explain: Comments: HOW DID YOU HEAR ABOUT US? WHO REFERRED YOU?				•		•		•	
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O Arthritis/Gout O Diabetes O Heart Murmur O Lung Disease O Stomach/Intestinal Disease O Artificial Heart Valve O Drug Addiction O Heart Pace Maker O Mitral Valve Prolapse O Stroke O Artificial Joint O Easily Winded O Heart Trouble/Disease O Pain in Jaw Joints O Swelling of Limbs O Asthma O Emphysema O Hemophilia O Parathyroid Disease O Thyroid Disease O Blood Disease O Epilepsy or Seizures O Hepatitis A O Psychiatric Care O Tonsillitis O Broathing Problem O Excessive Bleeding O Hepatitis B or C O Radiation Treatments O Tuberculosis O Breathing Problem O Excessive Thirst O Herpes O Recent Weight Loss O Tumors or Growths O Bruise Easily O Fainting Spells/Dizziness O High Blood Pressure O Renal Dialysis O Ulcers O Cancer O Frequent Cough O Hives or Rash O Rheumatic Fever O Venereal Disease O Chemotherapy O Frequent Diarrhea O Hypoglycemia O Rheumatism O Yellow Jaundice Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: Comments:					ilure				
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