## PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION 2 DATE DENTAL INSURANCE 1 LAST NAME FIRST M.I. PRIMARY CARRIER INSURANCE COMPANY PREFERS TO BE CALLED BY GROUP NO. ADDRESS IF THIS APPOINTMENT **EMPLOYER NAME** ZIP STATE CITY ISFOR YOU INSURED'S NAME WORK PHONE START HERE RELATIONSHIP TO PATIENT **EMAIL** DATE OF BIRTH CELL INSURED'S I.D. NO. FEMALE BIRTHDATE AGE MALE INSURED'S SOCIAL SECURITY NO. MARRIED SINGLE DIVORCED WIDOWED SOCIAL SECURITY NO. SECONDARY CARRIER INSURANCE COMPANY DATE GROUP NO. M.I. LAST NAME FIRST EMPLOYER NAME ADDRESS IF THIS APPOINTMENT IS ZIP INSURED'S NAME CITY STATE FOR YOUR CHILD RELATIONSHIP TO PATIENT DATE OF BIRTH START HERE HOME PHONE NO. INSURED'S I.D. NO. FEMALE BIRTHDATE AGE MALE INSURED'S SOCIAL SECURITY NO. GRADE SCHOOL SOCIAL SECURITY NO. IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO ACCOUNT INFORMATION 4 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT RELATIONSHIP TO PATIENT SOCIAL SECURITY NO. 3 **GETTING TO KNOW YOU** ADDRESS IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT ZIP CITY STATE AT OUR OFFICE? RELATIONSHIP: NAME: PHONE NO. YOU WERE REFERRED TO US BY YOU YOUR FORMER ADDRESS NAME STATE 71P OCCUPATION PERSON TO CONTACT FOR EMERGENCY EMPLOYER'S NAME PHONE NUMBER ADDRESS CITY PHONE NO. FAX NO. ADDRESS STATE ZIP YOUR SPOUSE CITY NAME CLOSEST RELATIVE NOT LIVING WITH YOU OCCUPATION PHONE NUMBER EMPLOYER'S NAME ADDRESS ADDRESS CITY STATE ZIP CITY PHONE NO. FAX NO.

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FORM 001-0301

Please turn over and sign

1.800.925.2600

PATIENT REGISTRATION

Heart Murmur Yes No Glaucoma Yes No Cold Sores/Fever Blisters Yes High/Low Blood Pressure Yes No Contact lenses Yes No Blood Transfusion Yes Mitral Valve Prolapse Yes No Emphysema Yes No Hemophilia Yes Artificial Heart Valve/Pacemaker Yes No Chronic Cough Yes No Sickle Cell Disease Yes Rheumatic Fever Yes No Tuberculosis Yes No Bruise Easily Yes Arthritis/Rheumatism Yes No Asthma Yes No Liver Disease/Yellow Jaundice Yes Cortisone Medicine Yes No Hay Fever/Allergy/Hives Yes No Neurological Disorders Yes Swollen Ankles Yes No Latex Sensitivity Yes No Epilepsy or Seizures Yes Stroke Yes No Radiation Therapy Yes No Nervous/Anxious Yes No Psychiatric/Psychological Care. Yes Kidney Trouble Yes No Tumors Yes No Tumors Yes No Yes No Psychiatric/Psychological Care.	tient Name MEDICAL HIST									
Have you had any medical care within the past two years?  Describe  2. Have you taken any medication or drugs during the past two years?  3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?  Yes  If yes, please list name and dosage  4. Have you ever taken prescription medications for weight loss (diet pills)?  If yes, did you take any of the following: (circle if yes)  Fen-Phen  Pondimen  Redux  Other  If yes to any of the above, did you have a medical exam for heart issues?  Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?  Yes  Have you been a patient in the hospital during the past five years?  Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.  Heart (Surgery, Disease, Attack). Yes  No  Diabetes  Yes  No  Hepatitis A B C (circle). Yes  Chest Pain  Yes  No  Libers  Yes  No  Hepatitis A B C (circle). Yes  Congenital Heart Disease  Yes  No  Diabetes  Yes  No  Libers  Yes  No  Lond Sores/Feer Blisters  Yes  Mitral Valve Prolapse  Yes  No  Contact lenses  Yes  No  Hemophilia  Yes  Artificial Heart Valve/Pacemaker  Yes  No  Liver Disease/Yellow Jauncice  Yes  No  Henophilia  Yes  Artificial Heart Valve/Pacemaker  Yes  No  Liver Disease/Yellow Jauncice  Yes  Swollen Ankles  Yes  No  Sincke Cell Disease  Yes  Swollen Ankles  Yes  No  Hay Fever/Allergy/Hives  Yes  No  Neurological Disorders  Yes  Swollen Ankles  Yes  No  Chemotherapy  Yes  No  Psychiatric/Psychological Care.  Yes  Kidney Trouble  Yes  No  Tumors  Yes  No  Tumors  Yes  No	ient Account No.			Medical Al	ert					
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Ves									10	
8. Are you aware of having an allergic (or adverse) reaction to any substance or medication?										No
9. Have you lost or gained more than 10 pounds in the past year?Yes										No
10. Do you have or have you had any disease, condition, or problem not listed?	10. Do you have or have you	had any disea	ise, con	dition, or problem not listed?					Yes	Ne
If yes, please list:	If yes, please list:	30,300							-	
11. Women: Are you pregnant or think you could be pregnant? YesMonths No Nursing? Yes No	11 Warmen Ara you proc	nant or think y	ou could	i be pregnant? Yes	Months	No	Nursing	g? Yes No	)	10000
12. Do you use birth control prescriptions? Yes	i. Promitin Alt you pitty								Yes	N
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