

## **Patient Registration**

First Name:	Last	. Name:	ti yez, wian is
Address:	- Add	Iress 2:	Doctor's name
City:	State/Zip:	Pager:	Picase explain
		ExtCellular:	If yes, what?
		Drivers Lic.:	
		ke to receive correspondences via e-mail.	
		ke to receive correspondences via e-mail.	
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SECTION 2	township test (ED VD e	nis UY UY Ballower Salaw	MAL YEL YO
DV DNTML	Time O Part Time O Retired	EMERGENCY CONTACT:	MA ALT VID
Student Status: O Full Time		more of AE AE modulanto	
O. 7. O. Versions Discuss	Pref. Dentist:	Market Market Co. 10 Market Ma	
	Pref. Pharmacy:	as found have said more the surfamence neithern	D 1 DN composite
	Pref. Hyg.:	, chew, use shift or any othersto lead to the	
PRIMARY INSURANCE			
Name of Insured:	Rela	ationship to Patient: O Self O Spouse O	Child O Other
	Insured Birth Date:		15. Do you have a
Employer:	Insu	ırance Company:	idens end el. I la magas explan
Address:	**************************************	Address:	
Address 2:	on to the first by equipment that each of the first of the	Address 2:	Dates
	City,	State, Zip:	
Rem. Benefits:	00 Rem. Deduct.: .00		
SECONDARY INSURAN	CE INFORMATION	a change in any madrophositic confidence.	bed nov system is a
Name of Insured:	Rela	ationship to Patient: O Self O Spouse	Child Other
Insured Soc. Sec.:	Insured Birth Date:		-1971
Employer:	Insu	urance Company:	
	ETHALMICE SETEMBOR	Address:	ITAG TOTAL
Address 2:		Address 2:	
City, State, Zip:	City,	State, Zip:	M11.2 = 1
Rem. Benefits:0	00 Rem. Deduct.: .00		



## **HEALTH HISTORY**

		ate:			
	M				
Please answer each question by checking the appropriate bo	x or circling Yes or No.		3/	N. 1 -	
1. Are you in good health?	Imag ynalygg		Yes	No	
2. Date of last physical examination:	STATES SECTION 1				
3. Are you now under the care of a physician?		••••••	Yes	No	
If yes, what is the condition being treated?	T. 1 "				
3. Are you now under the care of a physician?  If yes, what is the condition being treated?  Doctor's name:  4. Have you ever had any serious illness or operation or been here.	l elephone #:		Vac	Ma	
4. Have you ever had any serious illness or operation or been h	ospitalized?		res	No	
Please explain:  5. Are you taking any medication?			V	Ma	
5. Are you taking any medication?		• • • • • • • • • • • • • • • • • • • •	res	No	
If yes, what?  6. Are you using any recreational drugs (e.g., marijuana, cocain	What dosage?		1009 5	meH	
	ne) or controlled substances?		Yes	No	
If yes, what?	1 Charles latinals alone	O Male O E	17	N. I.	
7. Have you ever been premedicated with antibiotics for your d	ental treatment?		Yes	No	
8. Are you sensitive or allergic to any drugs or materials?	Penicillin La Tetracycline La Eryth	romycin	THE C	HIND	
☐ Aspirin ☐ Codeine ☐ Latex ☐ Other If Other, pl 9. Do you have or have you had any of the following: Please ch	ease list:		Yes	No	
9. Do you have or have you had any of the following: Please ch	neck "Y" for Yes or "N" for No — ansv	ver all conditions:			
☐ Y ☐ N AIDS ☐ Y ☐ N Cortisone Medicine	□ Y □ N Hemophilia	□Y □N Respirato	ry Disea	se	
Y N Allergies or Hives Y N Diabetes	DY DN Hernes	DY DN Rheumat	ism		
TV TN Anemia TY TN Drug Addiction	☐ Y ☐ N High Blood Pressure	□Y □N Sickle Ce	II Diseas	se	
□Y □N Angina Pectoris □Y □N Emphysema	☐ Y ☐ N HIV Positive	□Y □N Sinus Tro	ouble		
□ Y □ N Arthritis □ Y □ N Epilepsy or Seizures	☐ Y ☐ N Joint Replacement	□Y □N Stomach	Ulcers		
Y N Artificial Heart Valve Y N Excessive Bleeding	ures	DY DN TMJ	50111		
□ Y □ N Blood Disease □ Y □ N Glaucoma	□Y □N Mental Disorder	□Y □N Thyroid I	Disease		
9. Do you have or have you had any of the following: Please cr    Y	□ Y □ N Mitral Valve Prolapse	☐ Y ☐ N Tonsilliti	s		
☐ Y ☐ N Bruise Easily ☐ Y ☐ N Head Injuries	☐ Y ☐ N Nervous Disorders	OY ON Tubercule	osis Groudh	0.0	
☐ Y ☐ N Chemotherapy ☐ Y ☐ N Heart Ailments or Atta	V N Psychiatric Treatment	DY DN Venereal	Disease	15	
□ Y □ N Congenital Heart Lesions □ Y □ N Heart Murmur	☐ Y ☐ N Radiation Treatment		l sevo		
10. Do you wear a cardiac pacemaker, or have you had heart sur	gery? If yes, please explain:		Yes	No	
11.Do you smoke, chew, use snuff or any other forms of tobacc	o? Cigarettes Cigars Chew	Snuff Other	Yes	No	
If yes, how much?	MOTAMSO		Yes	No	
13. Have you ever taken the drug "Fen-Phen" or "Redux"?			Yes	No	
14. Are you pregnant? If yes, how many months?	97)	N/A	Yes	No	
15. Do you have any problems associated with your menstrual p	eriod?	N/A	Yes	No	
16 Do you take hirth control nills?		N/A	Yes	No	
17. Is there anything we should know about your health that is n	ot mentioned above?				
Please explain:			Yes	No	
Please explain:		- Page 1	Yes	No	
Ist I CERTIFY THAT THE ABOVE INFORMATION IS	COMPLETE AND ACCURATE.	resent	Yes	No	
Ist I CERTIFY THAT THE ABOVE INFORMATION IS  Date: Signature:		:2201	Yes	No	
Ist I CERTIFY THAT THE ABOVE INFORMATION IS  Date: Signature:		:2201	Yes	No	
Date: Signature: (If patient is a minor, inclu	de printed name and signature of paren	t or legal guardian)	Yes	icima	
Ist I CERTIFY THAT THE ABOVE INFORMATION IS  Date: Signature: (If patient is a minor, inclued a minor) inclued the second	de printed name and signature of paren  3rd UPDATE – Since your leading to the your leading to the since your leading to the your leadin	t or legal guardian)	Yes	igms ii)	
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