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o you use taken, Phen-Fen or Radux? Yes No J Yes										
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e you use tobacco?  Yes No  you use tobacco?  Yes No  reme: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?  you allogic to any of the following?  Suffa Drugs Codeine Acrylic Latex  Suffa Drugs Codeine Acrylic Latex  Suffa Drugs Codeine Acrylic Latex  Suffa Drugs Codeine Acrylic Codeine Acrylic Latex  Suffa Drugs Codeine Acrylic Codeine Codeine Acrylic Codeine Codeine Acrylic Codeine		-								
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Aspirin       Penicillin       Codeine       Acrylic         Metal       Latex       Sulfa Drugs       Local Anesthetics         o you use controlled substances?       Yes       No       If yes         their?       If yes       If yes       If yes         DS/HIV Positive       Yes       No       Drug Addiction       Yes       No         Inaphylaxis       Yes       No       Drug Addiction       Yes       No       Recent Weight Loss       Yes       No         Indemine Yes       No       Employaema       Yes       No       Hemophilia       Yes       No       Recent Weight Loss       Yes       No         Indemina       Yes       No       Employaema       Yes       No       Hemophilia       Yes       No       Recent Weight Loss       Yes       No         Indiniand       Yes       No       Epilepsy or Seizures       Yes       No       Heyestits B or C       Yes       No       Recent Weight Loss       Yes       No         Indiniand       Yes       No       Epilepsy or Seizures       Yes       No       Heyestits B       Yes       No       Singles       Yes       No         Indinidicaut       Yes       No	riegnand ri fing to g	et prognant:								
Metal       Latex       Sulfa Drugs       Local Anesthetics         or you use controlled substances?       Yes       No       If yes         out have, or have you had, any of the following?       Try set       Try set       No       Addition Treatments       Yes       No         Jzheimer's Disease       Yes       No       Cortisone Medicine       Yes       No       Addition Treatments       Yes       No         nemia       Yes       No       Cortisone Medicine       Yes       No       Hempthilis       Yes       No       Read Dialysis       Yes       No         naphylaxis       Yes       No       Easily Winded       Yes       No       Easily Winded       Yes       No       Read Dialysis       Yes       No         naphylaxis       Yes       No       Easily Winded       Yes       No       Recent Weight Loss       Yes       No         notificial Joint       Yes       No       Easily Winded       Yes       No       Scarlet Frever       Yes       No         Idoid Transfusion       Yes       No       Excessive Thirsts       Yes       No       Sinus Trouble       Yes       No         Idoid Transfusion       Yes       No       Frequent Diarrhea		he following?								
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DS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Radiation Treatments       Yes       No         naphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes       No         nemia       Yes       No       Easily Winded       Yes       No       Hepatitis A       Yes       No       Real Dialysis       Yes       No         ngina       Yes       No       Easily Winded       Yes       No       Herpes       Yes       No       Rheumatic Fever       Yes       No         tritificial Heart Valve       Yes       No       Excessive Thirst       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes       No         sthma       Yes       No       Faiting Spelk/Dizzness       Yes       No       Hives or Rash       Yes       No       Sinus Trouble       Yes       No         lood Disease       Yes       No       Frequent Cogh       Yes       No       Frequent Diarthea       Yes       No       Simus Trubule       Yes       No         lood Transfusion	ther?					If yes				
Lzheimer's Disease       Yes       No       Diabetes       Yes       No       Pres       No       Recent Weight Loss       Yes       No         naphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes       No         ngina       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Rheumatic Fever       Yes       No         ngina       Yes       No       Emphysema       Yes       No       Hepatitis A       Yes       No       Rheumatic Fever       Yes       No         ntrificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No       High Blood Pressure       Yes       No       Scinus Trouble       Yes       No         shma       Yes       No       Frequent Cough       Yes       No       High Blood Pressure       Yes       No       Scinus Trouble       Yes       No         lood Disease       Yes       No       Frequent Diarrhea       Yes       No       Keumatis       Yes       No       Scinus Trouble       Yes       No         lood Disease       Yes       No <td>you have, or have you</td> <td>had, any of the</td> <td>following?</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	you have, or have you	had, any of the	following?							
naphylaxis       Yes       No       Drug Addiction       Yes       No         nemia       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Renal Dialysis       Yes       No         ngina       Yes       No       Emphysema       Yes       No       High Blood Pressure       Yes       No       Rheumatism       Yes       No         triticial Hart Valve       Yes       No       Excessive Bleeding       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes       No         sthma       Yes       No       Fainting Spels/Diziness       Yes       No       Frequent Cough       Yes       No       Sinua Trouble       Yes       No         Yes       No       Frequent Cough       Yes       No       Genital Herpes       Yes       No       Sinua Trouble       Yes       No         Jaucoma       Yes       No       Glaucoma       Yes       No       Lever Disease       Yes       No       Sinua Trouble       Yes       No         Joad Transfusion       Yes       No       Glaucoma       Yes       No       Lever Biodod Pressure       Yes       No       <	IDS/HIV Positive	🔘 Yes 🔘 No	Cortisone Me	dicine	O Yes	O No	Hemophilia	🔘 Yes 🔘 No	Radiation Treatments	O Yes O N
nemia       Yes       No       Easily Winded       Yes       No         ngina       Yes       No       Emphysema       Yes       No         thrittis/Gout       Yes       No       Epilepsy or Seizures       Yes       No         tritticial Heart Valve       Yes       No       Excessive Bleeding       Yes       No         tritticial Joan       Yes       No       Excessive Bleeding       Yes       No         sthma       Yes       No       Fainting Spelk/Dizziness       Yes       No         food Transfusion       Yes       No       Frequent Cough       Yes       No         Frequent Cough       Yes       No       Frequent Cough       Yes       No         food Disease       Yes       No       Genital Herpes       Yes       No         careating Problems       Yes       No       Genital Herpes       Yes       No       Stomach/Intestnal Disease       Yes       No         heart Attack/Failure       Yes       No       Glaucoma       Yes       No       High Sole Prosure       Yes       No       Tomsliftis       Yes       No         odd Sores/Fever Bisters       Yes       No       Glaucoma       Yes <td< td=""><td>Izheimer's Disease</td><td>🔘 Yes 🔘 No</td><td>Diabetes</td><td></td><td>O Yes</td><td>O No</td><td>Hepatitis A</td><td>🔘 Yes 🔘 No</td><td>Recent Weight Loss</td><td>🔘 Yes 🔘 N</td></td<>	Izheimer's Disease	🔘 Yes 🔘 No	Diabetes		O Yes	O No	Hepatitis A	🔘 Yes 🔘 No	Recent Weight Loss	🔘 Yes 🔘 N
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lood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifida       Yes       No         lood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Frequent Diarrhea       Yes       No       Stomach/Intestinal Disease       Yes       No         ruise Easily       Yes       No       Genital Herpes       Yes       No       Genital Herpes       Yes       No       Swelling of Limbs       Yes       No         hemotherapy       Yes       No       Glaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Thyroid Disease       Yes       No         old Sores/Fever Bilsters       Yes       No       Heart Attack/Failure       Yes       No       Heart Pacemaker       Yes       No       Heart Nurmur       Yes       No       Parityroid Disease       Yes       No       Ulcers       Yes       No         ellow Jaundice       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Yes       No       Yes       No         ellow Jaundice       Yes       No       If yes       Mitral Yes       No       If yes       No		O Yes O No			O Yes	O No		O Yes O No	Sinus Trouble	O Yes O N
lood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes       No         reathing Problems       Yes       No       Genital Herpes       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes       No         ancer       Yes       No       Gaintal Herpes       Yes       No       Liver Disease       Yes       No       Swelling of Limbs       Yes       No         hemotherapy       Yes       No       Glaucoma       Yes       No       Hay Fever       Yes       No       Heart Attack/Failure       Yes       No       Tuberculosis       Yes       No         old Sores/Fever Blisters       Yes       No       Heart Attack/Failure       Yes       No       Heart Attack/Failure       Yes       No       Heart Attack/Failure       Yes       No       No       Tuberculosis       Yes       No         ongenital Heart Disorder       Yes       No       Heart Attack/Failure       Yes       No       Parathyroid Disease       Yes       No       Ucers       Yes       No         ellow Jaundice       Yes       No       Heart Trouble/Disease							-			
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ancer       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No         hemotherapy       Yes       No       Hay Fever       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       No         hemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsillitis       Yes       No         old Sores/Fever Blisters       Yes       No       Heart Attack/Failure       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         ongenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No         ellow Jaundice       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Mereral Disease       Yes       No         ave you ever had any serious illness not listed       Yes       No       If yes       I						_				
ancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No         hemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Thyroid Disease       Yes       No         hest Pains       Yes       No       Heart Attack/Failure       Yes       No       Mitral Valve Prolapse       Yes       No       Tuberculosis       Yes       No         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       No         ongenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       No         ellow Jaundice       Yes       No       Heart Trouble/Disease       Yes       No       If yes       If yes       If yes       Internal Valve Prolapse       Yes       No       No<	-									
Anemotherapy       Yes       No         Hay Fever       Yes       No         hemotherapy       Yes       No         hest Pains       Yes       No         old Sores/Fever Blisters       Yes       No         Heart Murmur       Yes       No         Heart Murmur       Yes       No         Heart Disorder       Yes       No         Heart Trouble/Disease       Yes       No         Heart Trouble/Disease       Yes       No         Heart Trouble/Disease       Yes       No         Heart Science       Yes       No         Heart Science       Yes       No         Heart Trouble/Disease       Yes       No         Prover Yes       No       If yes         And any serious illness not listed       Yes       No         If yes       If yes         Imments:       Imments:									5	_
hest Pains       Yes       No         old Sores/Fever Blisters       Yes       No         Heart Attack/Failure       Yes       No         Heart Murmur       Yes       No         Heart Murmur       Yes       No         Heart Disorder       Yes       No         Heart Trouble/Disease       Yes       No         Heart Trouble/Disease       Yes       No         Heart Trouble/Disease       Yes       No         Plow Jaundice       Yes       No         Ave you ever had any serious illness not listed       Yes       No         If yes       If yes		_			_	_	-	_		
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he best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my	he hest of my knowled	ine the question	ns on this form	have been	accurat	elv anew	ered Lunderstand that	providing incorre	ect information can be don	nerous to my

## Johnson Family Dentistry Patient Registration

First Name:	Middle Initial: Last Name:
	Responsible Party ( If someone other than the patient )
First Name:	Middle Initial: Last Name:
	City:State:Zip:
	Ottp:Ottp:Cell Phone:
Sex: Male Female	(Please check one) Date of Birth: Social Security:
Responsible Party is als (Please check one)	o a Policy Holder/Primary Insurance Policy Holder/Secondary Policy Holder
	Patient Information
First Name:	Middle Initial: Last Name:
Address:	City:State:Zip:
Home Phone:	Work Phone: Cell Phone:
Sex: Male Female	(Please check one) Date of Birth:Social Security:
Employment Status: Ful	l Time / Part Time / Retired (Please check one)
	Primary Insurance Information:
Name of Insured:	
Patient Relationship to	nsured: Self / Spouse / Child / Other
Insured Social Security:	Insured Date of Birth:
Insurance Company:	Insured Employer:
	Secondary Insurance Information:
Name of Insured:	
Patient Relationship to	nsured: Self / Spouse / Child / Other
Insured Social Security:	Insured Date of Birth:
Insurance Company:	Insured Employer: