PATIENT REGISTRATION



ID:	Chart ID:		
First Name:	Last Nar	ne:	Middle Initial:
Patient Is: Pol	icy Holder Responsible Party Preferred Nar	ne:	
Patient Inform	nation —		
Address:		Address 2:	
City:	State / Z		Pager:
Home Phone:	Work Phone:		Ext: Cellular:
Sex: Mal		us: Married Single	Divorced Separated Widowed
Birth Date:	Age:	Soc Sec:	Drivers Lic:
E-mail:		I would like to receive cor	
	Section 2		Section 3
Employment [Full Time Part Time Retired		Referred By
Status: Student Status:			Previous Dentist Emergency Contact
Medicaid ID:	Pref. Dentist:		* Emergency Contact #
Employer ID:	Pref. Pharmacy:		
Carrier ID:	Pref. Hyg:		
-		I	
Name of Insured:	ance Information	Deletie orlin to Income	
Insured Soc. Sec:	Insured E	Relationship to Insured	l: Self Spouse Child Other
Employer:	insured E	Ins. Company:	
Address:		Address:	
Address 2:		Address 2:	
City, State, Zip:		City, State, Zip:	
Rem. Benefits:	Rem. Deduct:		
Telli Belletiisi	Atom 2 tallet		
Responsible P	arty (if someone other than the patient)		
First Name:	Last Na	ne:	Middle Initial:
Address:		Address 2:	
City, State, Zip:			Pager:
Home Phone:	Work Phone:		Ext: Cellular:
Birth Date:	Soc Sec:		Drivers Lic:
Responsible Part	y is also a Policy Holder for Patient Primary Ins	urance Policy Holder	Secondary Insurance Policy Holder
Secondary In	surance Information		
Name of Insured:		Relationship to Insured	d: Self Spouse Child Other
Insured Soc. Sec:	Insured F	Sirth Date:	
Employer:		Ins. Company:	
Address:		Address:	
Address 2:		Address 2:	
City, State, Zip:		City, State, Zip:	
Rem. Benefits:	Rem. Deduct:		

Dentures Plus Implant and Dental Center MEDICAL HISTORY

Are you under a physicativic care row!	Patient Name	e:					Date:					
Here you ever that a serious head or neck injury? Are you taking nay medications, pile, or drugs? Do you take, or haive you taken, Phan Pen or Reduc? Here you ever taken Focamans, Sonwa, Actorel or any other medications containing sphosphonates? Are you are special diet? Do you use tabacco? Are you are special diet? Do you use tobacco? Yes No Tyes No Do you use tobacco? Yes No Do you use tobacco? Yes No To yes Women! Are you	Are you under a physi	cian's care no	w?	O Yes	○ No	If yes						
Are you taking any medications, pills, or drugs? If yes Do you take, or here you taken, Phen-Fen or Richus? If yes If yes If yes If yes Are you are taken Focusinas, terrius, Actional or any other medication controlling begin-prohomate? Are you are posed det? Ob you use tobaccor? Ob you use tobaccor? Ob you use tobaccor? If yes Women: Are you Pregnant/Trying to get pregnant? Are you allerigit to any of the following? Assir you be tobaccor? If yes Whetal	Have you ever been h	ospitalized or	had a ma	ajor operation? O Yes	○ No	If yes					10	
Are you taking any medications, pills, or drugs? Yes No If yes	Have you ever had a :	serious head o	or neck in	jury?	○ No	If ves						
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Have you are severablen Passarsa, Bornus, Actorel or any other Yes No If yes Are you are special det? Yes No If yes Women: Are you Phending or all contraceptives? Taking or all contraceptives? Women: Are you Phending or all contraceptives? Taking or all contraceptives? Are you alerge to any of the following? Pending Azarik Are you alerge to any of the following? Pending Azarik Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Yes No Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives? Are you alerge to any of the following? Taking or all contraceptives?	Are you taking any me	dications, pills	s, or drug								100	
Have you ever taken Fosaneax, Boniva, Actoned or any other mediactors containing bisphosphorates? Yes No	-	29 30	_	- 1 -								
medications containing bisphosphonaber? Are you on a special diet? Do you use controlled substances? Women: Are you Pregnant/Trying to get pregnant? Are you allergic to any of the following? Are you allergic to any of the following				010	O No	If yes					193	
Do you use tohacco? Do you use controlled substances? Women: Are you Pregnant/Trying to get pregnant? Are you allerge to any of the following? If yes Are you allerge to any of the following? Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the following? If yes No Radiation Treatments Are you allerge to any of the fol				nel or any other Yes	O No	If yes					-17	
No you use controlled substances? Yes No If yes	Are you on a special d	iet?		O Yes	○ No							
Women: Are you allerge: to any of the following? Are yes on bo Dubbets Are yes on bo Recent Weight Loss Redal bon Treatments A yes on be Recent Weight Loss Redal Dialysis Alterpain Any yes on bo Recent Weight Loss And Hepatitis A yes on bo Recent Weight Loss Read Dialysis A yes on bo Recent Weight Loss Read Dialysis Anend Dialysis Rend Dia	Do you use tobacco?			O Yes	O No							
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Penidlin Codeine Arrykc Local Anesthetics Other?	Do you use controlled	substances?		O Yes	○ No	If yes					P30	
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Penicillin Codeine Sulfa Drugs Local Anesthetics Other? If yes If y	Women: Are you											
Agayrin		get pregnan	t?	Nursing	j?			Taking	oral contr	aceptives?	-	1
Agayrin												
Other? Uhave, or have you had, any of the following? ShI-IV Positive	_	of the following	g?	D:-***-			E Cadaiar		-			7
Other? If yes				=						The second secon		
S/HIV Positive Yes No Cortisone Medicine Yes No Hemptilis A Yes No Recent Weight Loss Phylaxis Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Phylaxis Yes No Easily Winded Yes No Easily Winded Yes No Enphysema Yes No Enphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Recent Weight Loss Phylaxis Price No Easily Winded Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Recent Weight Loss Recent Weight Loss Recent Weight Loss Phylaxis Phylaxis Price No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Recent Weight Loss Recent Weight Loss Price No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Recent Weight Loss Price No Easily Winded Yes No Easily Winded Yes No Excessive Bleeding Yes No High Glood Pressure Yes No Scarlet Fever High Glood Pressure Yes No Scarlet Fever High Glood Pressure Yes No Fictial Heart Valve Yes No Excessive Firirst Yes No Frequent Cough Frequent Cough Yes No Frequent Cough Frequent Cough Frequent Disease Yes No Excessive Yes No Genital Herpes Yes No Genital Herpes Yes No Genital Herpes Yes No Hey Frequent Disease Yes No Hitral Valve Prolapse Yes No Thyroid Disease Thyroid Disease Yes No Heart Attack/Failure Yes No Parin Jaw Joints Yes No Tumors or Growths Ucers No Journal On The Production Yes No Davidor Service No Parin Jaw Joints Yes No Unicers Yes No Weight Loss No Heart Trouble/Disease Yes No Davidor Presure Yes No Davidor Ye	_ Metal			Latex			Sulla Drugs			ocal Ariestrieucs		
S/HU Positive Yes No Diabetes No Diabetes Yes No Diabetes						If yes					(e	
reimer's Disease						0	I., 1+	0	<u> </u>	lo trot u	0	_
phylaxis	•	_			_			_	_		O Yes	
mia											O Yes	
Ina	-				_	_		_	_		O Yes	
ritis/Gout	mia			The second secon							O Yes	S
Acial Heart Valve		O Yes C) No	Emphysema	O Yes	O No	Weelestown ones ep	O Yes	O No	Control expenses	O Yes	S
ficial Joint	nritis/Gout	Yes () No	Epilepsy or Seizures	Yes	O No	High Cholesterol	O Yes	O No	Scarlet Fever	O Yes	S
Prima	ficial Heart Valve	O Yes C) No	Excessive Bleeding	Yes	O No	Hives or Rash	O Yes	O No	Shingles	O Yes	S
and Disease	ficial Joint	O Yes C) No	Excessive Thirst	Yes	O No	Hypoglycemia	O Yes	O No	Sidde Cell Disease	O Yes	s
d Transfusion	nma	O Yes () No	Fainting Spells/Dizziness	Yes	O No	Irregular Heartbeat	O Yes	O No	Sinus Trouble	O Yes	S
athing Problems	od Disease	O Yes C) No	Frequent Cough	O Yes	O No	Kidney Problems	O Yes	O No	Spina Bifida	O Yes	s
se Easily	d Transfusion	O Yes () No	Frequent Diarrhea	Yes	O No	Leukemia	O Yes	O No	Stomach/Intestinal Disease	O Yes	s
Cer	athing Problems	() Yes () No	Frequent Headaches	O Yes	O No	Liver Disease	Yes	O No	Stroke	O Yes	s
Corr	se Easily	() Yes () No	Genital Herpes	O Yes	O No	Low Blood Pressure	Yes	O No	Swelling of Limbs	O Yes	
motherapy	cer		100000000000000000000000000000000000000	Glaucoma			Lung Disease	Yes	O No	Thyroid Disease	O Yes	
st Pains	motherapy			Hay Fever	-					Tonsillitis	O Yes	
d Sores/Fever Blisters			1444							Tuberculosis	O Yes	
genital Heart Disorder	l Sores/Fever Blisters										O Yes	
ow Jaundice			100000000000000000000000000000000000000		1200		No.	200	1000		O Yes	
ow Jaundice O Yes No Oxygen Supplement Used O Yes No e you ever had any serious illness not listed above? O Yes No e you ever been referred to a cardiologist? O Yes No					-				-			
e you ever had any serious illness not listed above? Yes No Yes No Yes No							rsychaut Care	() res	() NO	Veriereal Disease	O Yes	5
you ever been referred to a cardiologist?	ow Jaunuice	O res C).NO	Oxygen Supplement Osed	U Yes	O No						
	you ever had any seri	ous illness no	ot listed	above? O Yes	O No	If yes						
Comments	e you ever been referre	ed to a cardio	ologist?	O Yes	O No							
Сопінсню	Comments											
	Comments											

responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:	
X	Date:



DENTURES PLUS IMPLANT AND DENTAL CENTER OF KANSAS (dba DENTURES PLUS) 8630 Maurer Road Lenexa, Kansas 66219 913-227-0466

Patient Name:	Da	ate:	
Notice of Privacy Pract I may refuse to sign. Expiration: 3 years from I understand that I may I understand that my	ly request a copy of the pri PHI (Protected Health Infor	tson at Dentures Plus urance change; patient reaches age c	of 18
PLEASE LIST ANY OTH INFORMATION:	IER PARTIES WHO CAN HA	AVE ACCESS TO YOUR DENTAL	
Name:	Relationship:	Phone:	
Name:	Relationship:	Phone:	
		CONFIRM MY DENTAL MATION, AND INFORMATION	
□ Message on: Hor□ Email□ Any of the above	ne Phone Cell Phone Work	k Phone	
Please <i>p<u>rint</u></i> your name	 ?		
Please <u>sign</u> your name			
□ Patient □ Parent □ G	Guardian □ Other:		