Remark Dental

New Patient Registration and Medical History

Last Name_____ First Name _____ DOB_____

Street Address_____City_____State_____Zip_____

Email _____Social Security #_____

Phone (Home)_____ Phone (Work)_____

☐ Male

☐ Female

☐ Single

☐ Married

☐ Other

Name of Insured _____ DOB_____

ID # _____ Group #_____

Insured's Street Address_____ City _____

State _____ Zip_____ Relationship to patient_____

Insurance Plan Name and Address_____

_____

Primary Physician's Name _____ Practice _____

Are you experiencing/have you experienced any of the following? (Mark all that apply):

☐ Chronic Headaches	☐ HIV/AIDS	☐ Liver Disease
☐ Heart Problems	☐ Hepatitis	☐ Kidney Problems
☐ High/Low Blood Pressure	☐ Arthritis	☐ Seizures
☐ Circulatory Problems	☐ Epilepsy	☐ Tonsillitis
☐ Large Weight Gain/Loss	☐ Radiation Treatment	☐ Allergies (Please list below)
☐ Blood Disease	☐ Fainting Spells	_____

I affirm that the above information is accurate to the best of my knowledge and authorize the dental staff to perform any dental service that I may need. The dental staff is not responsible to for any errors that occur as a result of this form being incorrectly filled out.

Signature _____ Date _____