GRAVIC

# Remark Dental

## New Patient Registration and Medical History

Last Name Andrews First Name Nathan DOB 12/15/91

Street Address 801 Road St. City Malvern State PA Zip 19355

Email NAndrews@Gmail.com Social Security # 301-12-2130

Phone (Home) 610-355-5555 Phone (Work) N/A

- [x] Male
- [ ] Female

- [x] Single
- [ ] Married
- [ ] Other

Name of Insured Jessica Andrews DOB 9/20/70

ID # 60008057 Group # 9050601

Insured's Street Address 801 Road St. City Malvern

State PA Zip 19355 Relationship to patient Mother

Insurance Plan Name and Address Basic Insurance

356 W. East St., NY, NY

Primary Physician's Name Dr. Robert Davis Practice Malvern Med. Associates

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

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

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 Nathan Andrews Date 1/5/14

GRAVIC®

Remark Dental

## New Patient Registration and Medical History

Last Name Harvey First Name Katherine DOB 8/01/67

Street Address 101 West St. City West Chester State PA Zip 19382

Email KHarvey@gmail.com Social Security # 124-32-1212

Phone (Home) 555-601-6510 Phone (Work) 501-675-5757

☐ Male
■ Female

☐ Single
☐ Married
■ Other

Name of Insured ——— DOB ———

ID # 60015016 Group # 300756

Insured's Street Address ——— City ———

State ——— Zip ——— Relationship to patient Myself

Insurance Plan Name and Address Basic Insurance 356 W. East St., NY, NY

Primary Physician's Name Dr. Alice Green Practice Green Med. Associates

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 Weigh Gain/Loss | ☐ Radiation Treatment | ■ Allergies (Please list below) |
| ☐ Blood Disease | ■ Fainting Spells | Gluten |

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 Katherine Harvey Date 12/19/13

GRAVIC®

Remark Dental

## New Patient Registration and Medical History

Last Name Clark First Name Samuel DOB 9/5/01

Street Address 19 S. 3rd street City Malvern State PA Zip 19355

Email ——— Social Security # 183-31-3889

Phone (Home) 610-899-5555 Phone (Work) ———

- [x] Male
- [ ] Female

- [x] Single
- [ ] Married
- [ ] Other

Name of Insured Erica Clark DOB 3/10/71

ID # 60050896 Group # 70211895

Insured's Street Address 19 S. 3rd St. City Malvern

State PA Zip 19355 Relationship to patient Mother

Insurance Plan Name and Address Basic Insurance

356 W. East St. NY, NY 10036

Primary Physician's Name Dr. Karen Smith Practice Malvern Pediatrics

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

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

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 Samuel Clark Date 1/4/14

GRAVIC®

# Remark Dental

## New Patient Registration and Medical History

Last Name Sevant First Name Alec DOB 9/21/75

Street Address 100 W. First St. City West Chester State PA Zip 19382

Email Alecsevant@Gmail.com Social Security # 112-34-5678

Phone (Home) 809-908-9844 Phone (Work) 947-684-6679

- [x] Male
- [ ] Female

- [ ] Single
- [x] Married
- [ ] Other

Name of Insured Michelle Sevant DOB 12/3/77

ID # 08794881 Group # 1130065

Insured's Street Address 100 W. First St. City West Chester

State PA Zip 19382 Relationship to patient Wife

Insurance Plan Name and Address Best Insurance

118 Street N. Philadelphia, PA 19102

Primary Physician's Name Dr. Robert Davis Practice Malvern Med. Associates

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

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

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 Alec Sevant Date 12/13/13

GRAVIC®

Remark Dental

## New Patient Registration and Medical History

Last Name Aiken First Name Jaquelin DOB 7/18/99

Street Address 55 west st. City Malvern State PA Zip 19355

Email JaquelinAiken@aim.com Social Security # 133-33-5567

Phone (Home) 610-555-8558 Phone (Work) N/A

☐ Male
■ Female

■ Single
☐ Married
☐ Other

Name of Insured Lauren Aiken DOB 10/5/69

ID # 75001038 Group # 8870086

Insured's Street Address 55 west. st. City Malvern

State PA Zip 19355 Relationship to patient Mother

Insurance Plan Name and Address Best Insurance

118 street In., Philadelphia PA 19102

Primary Physician's Name Dr. Karen Smith Practice Malvern Pediatrics

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 Weigh 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 Jaquelin Aiken Date 1/5/14

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Remark Dental

## New Patient Registration and Medical History

Last Name McDonough First Name Anthony DOB 5/25/86

Street Address 124 First St. City West Chester State PA Zip 19382

Email AMCDonough@aol.com Social Security # 123-44-5678

Phone (Home) 610-333-4444 Phone (Work) N/A

- [x] Male
- [ ] Female

- [ ] Single
- [x] Married
- [ ] Other

Name of Insured ——— DOB ———

ID # 0083215 Group # 661308

Insured's Street Address ——— City ———

State ——— Zip ——— Relationship to patient Self

Insurance Plan Name and Address Basic Insurance

356 W. East St., NY, NY, 10036

Primary Physician's Name Dr. David Green Practice Green Med. Associates

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

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

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 Anthony McDonough Date 12/18/13

GRAVIC®

Remark Dental

## New Patient Registration and Medical History

Last Name Keeport First Name Grace DOB 4/15/58

Street Address 120 West Blvd. City Malvern State PA Zip 19355

Email Gkeeport@comcast.net Social Security # 105-55-5100

Phone (Home) 302-203-3002 Phone (Work) 605-555-5066

☐ Male

☐ Female

☐ Single

☐ Married

☐ Other

Name of Insured Grace Keeport DOB 4/15/58

ID # 7090160 Group # 005430

Insured's Street Address 120 West Blvd. City Malvern

State PA Zip 19355 Relationship to patient Self

Insurance Plan Name and Address Basic Insurance

365 W. East St., NY, NY. 10036

Primary Physician's Name Dr. Alice Smith Practice Green Med. Associates

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 Weigh 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 Grace Keeport Date _____

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Remark Dental

## New Patient Registration and Medical History

Last Name Lacrouse First Name Ian DOB 6/5/90

Street Address 85 North Ave. City West Chester State PA Zip 19382

Email IanLacrouse@aol.com Social Security # 332-21-2331

Phone (Home) 806-555-9951 Phone (Work) _____

■ Male
☐ Female

■ Single
☐ Married
☐ Other

Name of Insured Diane Lacrouse DOB 9/9/69

ID # 706859981 Group # 6518979

Insured's Street Address 85 North Ave. City West Chester

State PA Zip 19382 Relationship to patient Mother

Insurance Plan Name and Address Best Insurance

118 Street In., Philadelphia, PA 19102

Primary Physician's Name Dr. David Green Practice Green Med. Associates

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 Weigh 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 Ian Lacrouse Date 12/30/13

GRAVIC

Remark Dental

## New Patient Registration and Medical History

Last Name McDewett First Name Rachel DOB 10/12/70

Street Address 55 West blvd. City Malvern State PA Zip 19355

Email RMcDewett@aol.com Social Security # 123-34-4567

Phone (Home) 615-550-5016 Phone (Work) N/A

☐ Male
■ Female

☐ Single
■ Married
☐ Other

Name of Insured Mark McDewett DOB 11/15/70

ID # 7065438 Group # 77648001

Insured's Street Address 55 West blvd. City Malvern

State PA Zip 19355 Relationship to patient Husband

Insurance Plan Name and Address Generic Insurance

25 Street blvd. Greensboro NC, 27499

Primary Physician's Name Dr. Debra Wilson Practice Malvern Med. associates

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 Weigh 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 Rachel McDewett Date 12/01/13

GRAVIC®

# Remark Dental

## New Patient Registration and Medical History

Last Name Chillot First Name Daniel DOB 6/18/95

Street Address 32 N. South St. City West Chester State PA Zip 19382

Email DanielChillot@gmail.com Social Security # 123-45-6789

Phone (Home) 610-555-3001 Phone (Work) 302-801-1055

■ Male
☐ Female

■ Single
☐ Married
☐ Other

Name of Insured David Chillot DOB 9/14/65

ID # 3285567809 Group # 946788200

Insured's Street Address 32 N. South St. City West Chester

State PA Zip 19382 Relationship to patient father

Insurance Plan Name and Address Generic Insurance

25 Street blvd. Greensboro NC, 27499

Primary Physician's Name Dr. Alice Green Practice Green Med. Associates

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 Weigh Gain/Loss | ☐ Radiation Treatment | ■ Allergies (Please list below) |
| ☐ Blood Disease | ☐ Fainting Spells | anesthesia |

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 Daniel Chillot Date 1/7/14