

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

Male
 Female

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

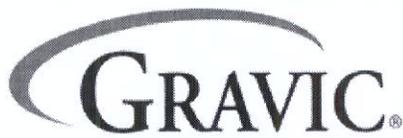
Primary Physician's Name Dr. Robert Davis Practice Malvern Med. Associates

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

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input checked="" type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input checked="" type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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 Nathan Andrews Date 1/5/14



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

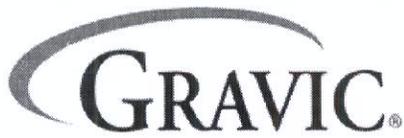
Primary Physician's Name Dr. Alice Green Practice Green Med. Associates

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

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input checked="" type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input checked="" type="checkbox"/> Fainting Spells	<u>Gluten</u>

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



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) _____

Male
 Female

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

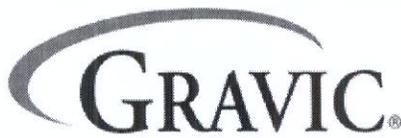
Primary Physician's Name Dr. Karen Smith Practice Malvern Pediatrics

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

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input checked="" type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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 Samuel Clark Date 1/4/14



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

Male
 Female

Single
 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 In. 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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input checked="" type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weight Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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 for any errors that occur as a result of this form being incorrectly filled out.

Signature Alec Sevant Date 12/13/13



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 # 133-33-6567
 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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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



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

Male
 Female

Single
 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):

<input checked="" type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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 Anthony McDonough Date 12/18/13



Remark Dental

New Patient Registration and Medical History

Last Name Keepert First Name Grace DOB 4/15/58
 Street Address 120 West Blvd. City Malvern State PA Zip 19355
 Email Gkeepert@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 Keepert 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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input checked="" type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input checked="" type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weight Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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 for any errors that occur as a result of this form being incorrectly filled out.

Signature Grace Keepert Date _____



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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input checked="" type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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



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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> 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



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):

<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tonsillitis
<input checked="" type="checkbox"/> Large Weigh Gain/Loss	<input type="checkbox"/> Radiation Treatment	<input checked="" type="checkbox"/> Allergies (Please list below)
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Fainting Spells	<u>anesthesia</u>

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