Genesis Health Agency Patient Registration

Patient Information

<table>
<tr><td>First Name:</td><td>Middle Initial:</td><td>Last Name:</td></tr>
<tr><td>Preferred Name:</td><td>Gender:</td><td>Date of Birth:</td></tr>
<tr><td colspan="3">Patient is: [ ] Policyholder [ ] Responsible Party [ ] Insured</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>Marital Status
[ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed</td><td>Home/Work Phone:</td><td>Cell Phone:</td></tr>
<tr><td>Social Security Number:</td><td colspan="2">Driver's License:</td></tr>
<tr><td colspan="3">Email:
[ ] I would like to receive correspondence via email</td></tr>
<tr><td>Employment Status
[ ] Full Time [ ] Part Time
[ ] Retired [ ]Unemployed</td><td colspan="2">Student Status
[ ] Full Time [ ] Part Time
[ ] Not In School</td></tr>
<tr><td>Medicaid ID</td><td>Employer ID</td><td>Carrier ID</td></tr>
<tr><td>Preferred Dentist</td><td>Preferred Pharmacy</td><td>Preferred Hygienist</td></tr>
</table>

Responsible Party (if someone other than the patient)

<table>
<tr><td colspan="2">First Name:</td><td colspan="2">Middle Initial:</td><td colspan="2">Last Name:</td></tr>
<tr><td colspan="6">Address:</td></tr>
<tr><td colspan="2">Home Phone:</td><td colspan="2">Cell Phone:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td colspan="3">Social Security</td><td colspan="3">Driver’s License:</td></tr>
<tr><td colspan="6">Responsible Party:
[ ] Responsible Party is also a Policyholder for Patient
[ ] Primary Insurance Policyholder
[ ] Secondary Insurance Policyholder</td></tr>
</table>

Primary Insurance Information

<table>
<tr><td colspan="3">Name of Insured:</td></tr>
<tr><td>Relationship to Insured:</td><td>Insured Social Security Number:</td><td>Insured Birthdate:</td></tr>
</table>

Employer	**Employer Address**
Reimbursement Benefits	**Reimbursement Deductible**
Insurance Company	**Insurance Company Address**

Secondary Insurance Information

<table>
<tr><td colspan="6">Name of Insured:</td></tr>
<tr><td colspan="2">Relationship to Insured:</td><td colspan="2">Insured Social Security Number:</td><td colspan="2">Insured Birthdate:</td></tr>
<tr><td colspan="3">Employer</td><td colspan="3">Employer Address</td></tr>
<tr><td colspan="3">Reimbursement Benefits</td><td colspan="3">Reimbursement Deductible</td></tr>
<tr><td colspan="3">Insurance Company</td><td colspan="3">Insurance Company Address</td></tr>
</table>

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could interfere with treatment.

Are you under a physician's care now? Yes or No

Have you been hospitalized or had a major operation? Yes or No

Have you ever had a serious head or neck injury? Yes or No

Are you taking any medications, pills, or drugs? Yes or No

Do you take or have you taken Phen-Pen or Redux? Yes or No

Have you ever taken Fosamax, Boniva, Actonel or any other medications contain bisphosphonates? Yes or No

Are you on a special diet? Yes or No

Do you use tobacco? Yes or No

Do you use controlled substances? Yes or No

Are you allergic to any of the following? Please check all that apply.

[ ] Aspirin
[ ] Penicillin
[ ] Codeine
[ ] Acrylic
[ ] Metal
[ ] Latex
[ ] Sulfa Drugs
[ ] Local Anesthetics
[ ] Other

Women, are you?

[ ] Pregnant/Trying to Get Pregnant
[ ] Nursing
[ ] Taking oral contraceptives

Do you have or have you had any of the following?

Please circle

AIDS/HIV Positive Yes or No
Alzheimer's Disease Yes or No
Anaphylaxis Yes or No
Anemia Yes or No
Angina Yes or No
Arthritis/Gout Yes or No
Artificial Heart Valve Yes or No
Artificial Joint Yes or No
Asthma Yes or No
Blood Disease Yes or No
Blood Transfusion Yes or No
Breathing Problems Yes or No
Bruise Easily Yes or No
Cancer Yes or No
Chemotherapy Yes or No
Chest Pains Yes or No
Cold Sores/Fever Blisters Yes or No
Congenital Heart Disorder Yes or No
Convulsions Yes or No
Cortisone Medicine Yes or No
Diabetes Yes or No
Drug Addiction Yes or No
Easily Winded Yes or No
Emphysema Yes or No
Epilepsy or Seizures Yes or No
Excessive Bleeding Yes or No
Excessive Thirst Yes or No
Fainting Spells/Dizziness Yes or No
Frequent Cough Yes or No
Frequent Diarrhea Yes or No
Frequent Headaches Yes or No
Genital Herpes Yes or No
Glaucoma Yes or No
Hay Fever Yes or No
Heart Attack/Failure Yes or No
Heart Murmur Yes or No
Heart Pacemaker Yes or No
Heart Trouble/Disease Yes or No
Hemophilia Yes or No
Hepatitis A Yes or No
Hepatitis B or C Yes or No
Herpes Yes or No

High Blood Pressure Yes or No
High Cholesterol Yes or No
Hives or Rash Yes or No
Hypoglycemia Yes or No
Irregular Heartbeat Yes or No
Kidney Problems Yes or No
Leukemia Yes or No
Liver Disease Yes or No
Low Blood Pressure Yes or No
Lung Disease Yes or No
Irregular Heartbeat Yes or No
Mitral Valve Prolapse Yes or No
Osteoporosis Yes or No
Pain in Jaw Joints Yes or No
Parathyroid Disease Yes or No
Psychiatric Care Yes or No
Radiation Treatments Yes or No
Recent Weight Loss Yes or No
Renal Dialysis Yes or No

Rheumatic Fever Yes or No
Rheumatism Yes or No
Scarlet Fever Yes or No
Shingles Yes or No
Sickle Cell Disease Yes or No
Sinus Trouble Yes or No
Spina Bifida Yes or No
Stomach/Intestinal Disease Yes or No
Stroke Yes or No
Swelling of Limbs Yes or No
Thyroid Disease Yes or No
Tonsillitis Yes or No
Tuberculosis Yes or No
Tumors or Growths Yes or No
Ulcers Yes or No
Venereal Disease Yes or No
Swelling of Limbs Yes or No
Yellow Jaundice Yes or No

Have you ever had any serious illness not listed above? Yes or No
If yes, please explain: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: ______________________________________
Print Name: ____
Date: ______________________