TIME 11:44 AM

PATIENT REGISTRATION

DATE 2/19/2018

| ID:                          | Chart ID:                          |                     |                             |                 |                               |                   |
|------------------------------|------------------------------------|---------------------|-----------------------------|-----------------|-------------------------------|-------------------|
| First Name:                  | ame:                               |                     |                             |                 |                               | Middle Initial:   |
| Patient Is: Policy Hold      | Policy Holder Responsible Party    |                     |                             |                 |                               |                   |
| Responsible Party ( if       | someone other than the patient ) - |                     |                             |                 |                               |                   |
| First Name:                  |                                    | Last Name:          |                             |                 |                               | Middle Initial:   |
| Address:                     |                                    | Address             | 2:                          |                 |                               |                   |
| City, State, Zip:            |                                    |                     |                             |                 |                               | Pager:            |
| Home Phone:                  | Work Phone                         |                     |                             | Ext:            | C                             | Cellular:         |
| Birth Date:                  | Soc Sec                            |                     |                             | Drivers         | Lic:                          |                   |
| Responsible Party is also    | a Policy Holder for Patient        | Primary Insurance P | olicy Holder                | Se              | econdary Insura               | nce Policy Holder |
| ——— Patient Information –    |                                    |                     |                             |                 |                               |                   |
| Address:                     |                                    | Address 2           | 2:                          |                 |                               |                   |
| City:                        |                                    | State / Zip:        |                             |                 |                               | Pager:            |
| Home Phone:                  | Work Phone:                        |                     |                             | Ext:            | C                             | ellular:          |
| Sex: Male                    | Female                             | Marital Status: M   | arried Single               | Divorced        | Separated                     | Widowed           |
| Birth Date:                  | Age:                               | Soc So              | ec:                         | Drivers         | Lic:                          |                   |
| E-mail:                      |                                    |                     | would like to receive corre | espondences via | e-mail.                       |                   |
|                              | - Section 2                        |                     |                             |                 | - Section                     | 3                 |
| Employment Full 7<br>Status: | Time Part Time                     | Retired             |                             | D               | Referred By                   |                   |
| Student Status: Full 7       | Time Part Time                     |                     |                             |                 | vious Dentist<br>ency Contact |                   |
| Medicaid ID:                 | Pref. Der                          | ntist:              |                             |                 | cy Contact #                  |                   |
| Employer ID:                 | Pref. Pharm                        | acy:                |                             |                 |                               |                   |
| Carrier ID:                  | Pref. 1                            |                     |                             |                 |                               |                   |
| Primary Insurance Inf        |                                    |                     |                             |                 |                               |                   |
| Name of Insured:             | ormation —                         |                     | Relationship to Insured:    | Self            | Spouse                        | Child Other       |
| Insured Soc. Sec:            |                                    | Insured Birth Date  | -                           | Sell            |                               |                   |
| Employer:                    |                                    |                     | Ins. Company:               |                 |                               |                   |
| Address:                     |                                    |                     | Address:                    |                 |                               |                   |
| Address 2:                   |                                    |                     | Address 2:                  |                 |                               |                   |
| City, State, Zip:            |                                    |                     | City, State, Zip:           |                 |                               |                   |
| Rem. Benefits:               | Ren                                | n. Deduct:          | City, State, Zip.           |                 |                               |                   |
|                              |                                    | . Deduct.           |                             |                 |                               |                   |
| Secondary Insurance          | Information ———                    |                     |                             |                 |                               |                   |
| Name of Insured:             |                                    |                     | Relationship to Insured:    | Self            | Spouse                        | Child Other       |
| Insured Soc. Sec:            |                                    | Insured Birth Date  |                             |                 |                               |                   |
| Employer:                    |                                    |                     | Ins. Company:               |                 |                               |                   |
| Address:                     |                                    |                     | Address:                    |                 |                               |                   |
| Address 2:                   |                                    |                     | Address 2:                  |                 |                               |                   |
| City, State, Zip:            |                                    |                     | City, State, Zip:           |                 |                               |                   |
| Rem. Benefits:               | Ren                                | n. Deduct:          |                             |                 |                               |                   |

Patient Name:

## Watermark Dental Powell Eaglesoft Medical History Birth Date:

Date Created:

Date:

Date 2/19/2018

| Me you under a physican's care now?  Ves No  fy yes  Have you ever been hospitalized or had a mglor operation?  Ves No  fy yes  Have you ever been hospitalized or had a mglor operation?  Ves No  fy yes  Do you take, or have you taken, Phen Fen or Redux?  Ves No  fy yes  Do you take, or have you taken, Phen Fen or Redux?  Ves No  fy yes  Do you take, or have you taken, Phen Fen or Redux?  Ves No  Do you take, or have you taken, Phen Fen or Redux?  Ves No  Do you take, or have you taken, Phen Fen or Redux?  Ves No  Do you take, or have you taken, Phen Fen or Redux?  Ves No  Do you take, or have you taken, Phen Fen or Redux?  Ves No  Do you use controlled aubstances?  Ves No  Do you use controlled aubstances?  Ves No  Pergrannt/Trying to get pregnant?  Aubsing?  Aubsin  | Have you ever been hospitalized or had a major operation?       Yes       No       If         Have you ever had a serious head or neck injury?       Yes       No       If         Are you taking any medications, pills, or drugs?       Yes       No       If         Do you take, or have you taken, Phen-Fen or Redux?       Yes       No       If         Have you ever taken Fosamax, Boniva, Actonel or any other       Yes       No       If         Have you on a special diet?       Yes       No       If         Are you on a special diet?       Yes       No       If         Do you use tobacco?       Yes       No       If         Do you use controlled substances?       Yes       No       If         omen: Are you   | yes yes yes yes yes Codeine Codeine Codeine Sulfa Drugs Local Anesthetics yes Hepatitis A Yes Yes Recent Weight Loss Yes Recent Weight Loss Yes Renal Dialysis Yes Renal Dialysis Yes   |
|---|---|---|
| tave you ever had a serious head or next injury? Ves No if yes vou take, Phen-Fen or Redux? Ves No if yes vou take, phen-Fen or Redux? Ves No if yes vou ever taken Fosamax, Boriva, Actorel or any other Ves No a good take, phen-Fen or Redux? Ves No if yes ve you as controlled substances? Ves No vou use controlled substances? Ves No vou as controlled substances? Ves No vou allergo to any of the following? Activity of the following? Activity of the following? Activity of the following? Activity of the following? Attemation of the fo  | Have you ever had a serious head or neck injury?       Yes       No       If         Are you taking any medications, pills, or drugs?       Yes       No       If         Do you take, or have you taken, Phen-Fen or Redux?       Yes       No       If         Have you ever taken Fosamax, Boniva, Actonel or any other       Yes       No       If         Have you on a special diet?       Yes       No       If         Do you use tobacco?       Yes       No       If         Do you use controlled substances?       Yes       No       If         Do you use controlled substances?       Yes       No       If         Immen: Are you   | yes yes yes yes yes<br>Taking oral contraceptives?<br>Codeine<br>Codeine<br>Sulfa Drugs<br>Hemophilia<br>Hemophilia<br>Hepatitis A<br>Hepatitis B or C<br>Hepatitis B or C<br>H |
| re you take, or have you taken, Phen-Flen or Redux? Yes No If yes   | re you taking any medications, pills, or drugs?<br>Yes No If<br>to you take, or have you taken, Phen-Fen or Redux?<br>Yes No If<br>lave you ever taken Fosamax, Boniva, Actonel or any other<br>re you on a special diet?<br>Yes No<br>Yes No<br>If<br>Yes No<br>Yes No<br>Yes No<br>If<br>Yes No<br>Yes No<br>If<br>Metal<br>Aspirin<br>Aspirin<br>Metal<br>Yes No<br>Yes No<br>If<br>You allergic to any of the following?<br>Aspirin<br>Metal<br>Yes No<br>Xether?<br>Yes No<br>Xether?<br>Yes No<br>Xether?<br>Yes No<br>Alzheimer's Disease<br>Yes No<br>Anaphylaxis<br>Yes No<br>Anaphylaxis<br>Yes No<br>Arthritis/Gout<br>Yes No<br>Yes No<br>Yes No<br>Yes No<br>Yes No<br>Emphysema<br>Yes No<br>Excessive Bleeding<br>Yes No<br>Xether Yes No<br>Yes | yes yes yes yes yes Codeine Taking oral contraceptives? Codeine Sulfa Drugs Local Anesthetics yes Hepatitis A Yes No Hepatitis B or C Yes Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hepatitis Pres Yes No Hepatitis Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye   |
| vo utaliac, or have you taken, Phen-Fen or Redux? Vec 0, No If yee edealsons containing biophosphorate? Vec 0, No If yee edealsons controlled substance? Vec 0, No If yee edealson Vec 0, No If yee No  | o you take, or have you taken, Phen-Fen or Redux?       Yes       No       If         have you ever taken Fosamax, Boniva, Actonel or any other       Yes       No       If         have you on a special diet?       Yes       No       If         no you use tobacco?       Yes       No       If         no you use tobacco?       Yes       No       If         no you use controlled substances?       Yes       No       If         men: Are you       Pregnant/Trying to get pregnant?       Nursing?         Aspirin       Penicillin       Netal       If         Metal       Latex       If         you have, or have you had, any of the following?       If       If         you have, or have you had, any of the following?       If       If         AlDS/HIV Positive       Yes       No       If         you have, or have you had, any of the following?       If       If         Anaphylaxis       Yes       No       Drug Addiction       Yes       No         Anaphylaxis       Yes       No       Drug Addiction       Yes       No         Arthritis/Gout       Yes       No       Emphysema       Yes       No         Arthritis/Gout       Yes       No   | yes yes yes Taking oral contraceptives?  Codeine Taking oral contraceptives?  Codeine Codeine Acrylic Sulfa Drugs Local Anesthetics  yes Hepatitis A Yes No Hepatitis A Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hepatitis Pres Yes Yes Yes Yes Yes Yes Yes Yes Yes Y   |
| ave you ever taken Fosamax, Boniva, Actonel or any other<br>edications containing bighpophonates?<br>re you are taken?<br>re you are taken?<br>you all edit?<br>you are taken?<br>you you are taken?<br>you | ave you ever taken Fosamax, Boniva, Actonel or any other<br>edications containing bisphosphonates?       Yes       No       If         re you on a special diet?       Yes       No       Over Solution       Yes       No         o you use tobacco?       Yes       No       If       Over Solution       Yes       No         o you use tobacco?       Yes       No       Over Solution       Yes       No       If         men: Are you       Pregnant/Trying to get pregnant?       Nursing?       If         wou allergic to any of the following?       Aspirin       Penicillin       If         Metal       Latex       If       If         you have, or have you had, any of the following?       If       If         you have, or have you had, any of the following?       If       If         AlDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No         Alzheimer's Disease       Yes       No       Drug Addiction       Yes       No         Anaphylaxis       Yes       No       Easily Winded       Yes       No         Aremia       Yes       No       Emphysema       Yes       No         Argina       Yes       No       Epilepsy or Seizures       Yes  | yes yes Taking oral contraceptives?  Codeine Codeine Sulfa Drugs  Hemophilia Yes Ves Hepatitis A Yes No Hepatitis B or C Yes Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hepatitis Por  |
| edeclations containing biophosphonates?   | edications containing bisphosphonates?  re you on a special diet?  re you on a special diet?  o you use tobacco?  o you use controlled substances?  Pregnant/Trying to get pregnant?  you allergic to any of the following?  Aspirin  Metal  Latex  ther?  If:  you have, or have you had, any of the following?  NIDS/HIV Positive  Yes No  Cortisone Medicine  Yes No  Anaphylaxis  Yes No  Cortisone Medicine  Yes No  Anaphylaxis  Yes No  Cortisone Medicine  Yes No  Anaphylaxis  Yes No  Easily Winded  Yes No  Anaphylaxis  Yes No  Easily Winded  Yes No  Anaphylaxis  Yes No  Cortisone Secures  Yes No  Cortisone  Yes No  | yes Taking oral contraceptives?  Codeine Sulfa Drugs Local Anesthetics  Yes Hemophilia Yes No Hepatitis A Yes No Hepatitis B or C Yes Yes Yes No Herpes Yes No Herpes Yes No Recent Weight Loss Yes Renal Dialysis Yes Renal Dialysis Yes Recent Yes Recent Yes   |
| you use boacco? Ves No Yes No   | o you use tobacco?       O Yes O No         o you use controlled substances?       O Yes O No         inen: Are you       O Yes O No         Pregnant/Trying to get pregnant?       O Norsing?         you allergic to any of the following?       O Yes O No         Aspirin       O Penicillin         Metal       O Latex         ther?       If         you have, or have you had, any of the following?       If         Muse or have you had, any of the following?       If         Muse or have you had, any of the following?       If         you have, or have you had, any of the following?       If         Muse or have you had, any of the following?       If         Muse or have you had, any of the following?       If         you have, or have you had, any of the following?       Drug Addiction         Virgit Addiction       Yes O No         Indetes       O Yes O No         Indetes       O Yes O No         Indetes       O Yes O No         Ingina       Yes O No         withficial Heart Valve       Yes O No         withficial Heart Valve       Yes O No         Excessive Bleeding       O Yes O No  |   |
| or you use controlled substances?       Ves       No       If yes         men: Are you  | o you use controlled substances?           O yes       No       If         men: Are you       Pregnant/Trying to get pregnant?       Nursing?         Pregnant/Trying to get pregnant?       Nursing?         Aspirin       Penicillin         Metal       Latex         ther?       If         you have, or have you had, any of the following?       If         AIDS/HIV Positive       Yes       No         Alzbeimer's Disease       Yes       No         Anaphylaxis       Yes       No         Angina       Yes       No         Arthritis/Gout       Yes       No         Arthritis/Gout       Yes       No         Arthriticial Heart Valve       Yes       No  |   |
| metri: Are you         Pregnant/Trying to get pregnant?       Nursing?         Jaspirin       Peridlin         Jaspirin       Peridlin         Jetal       Latex         Sulfa Drugs       Local Anesthetics         ther?       If yes         prou have, or have you had, any of the following?       If yes         Lib/HV Positive       Yes <no< td="">         Lib/HV Positive       Yes<no< td="">         Diabetes       Yes<no< td="">         Inaph/nais       Yes<no< td="">         Drug Addiction       Yes<no< td="">         Inaph/Nais       Yes<no< td="">         Drug Addiction       Yes<no< td="">         Ingina       Yes<no< td="">         Emphysema       Yes<no< td="">         Emphysema       Yes<no< td="">         Englapsy or Seizzes       Yes<no< td="">         Hypes/Cont       Yes<no< td="">         Englapsy or Seizzes       Yes<no< td="">         Hypes/Cont       Yes<no< td="">         Englapsy or Seizzes       Yes<no< td="">         Englapsy</no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<></no<>  | men: Are you Pregnant/Trying to get pregnant? you allergic to any of the following? Aspirin Metal Detex ther? If you have, or have you had, any of the following? NIDS/HIV Positive Yes Yes No Vacheimer's Disease Yes Yes No Unaphylaxis Yes No Easily Winded Yes No Krifficial Heart Valve Yes No Excessive Bleeding Yes No   |   |
| nen: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?  vou allergic to any of the following?  Acryic  Acryic  Acryic  Acryic  Acryic  Acryic  Acryic  Codeine  Acryic   | men: Are you Pregnant/Trying to get pregnant? Nursing? you allergic to any of the following? Aspirin Metal Detex ther? If you have, or have you had, any of the following? NIDS/HIV Positive Yes Yes No Natheimer's Disease Yes Yes No Diabetes Yes No Diabetes Yes No Namemia Yes No Easily Winded Yes No wrthritis/Gout Yes No Epilepsy or Seizures Yes No Excessive Bleeding Yes No  | Codeine       Acrylic         Sulfa Drugs       Local Anesthetics         yes       Acrylic         Hemophilia       Yes         Hepatitis A       Yes         Hepatitis B or C       Yes         Herpes       Yes         No       Renal Dialysis         Herpes       Yes   |
| Prepnant/Trying to get prepnant?       Nursing?       Taking or al contraceptives?         you allergic to any of the following?       Previollin       Codeine       Acrylic         Japprin       Previollin       Codeine       Acrylic         Metal       Latex       Sulfa Drugs       Local Anesthetics         ther?       If yes        Reacht Weight Loss       Yes         proubave, or have you had, any of the following?          Reacht Weight Loss       Yes         abb/Hit Positive       Yes       No       Cortisone Medicine       Yes       No       Readiation Treatments       Yes         anaphylaxis       Yes       No       Easily Winded       Yes       No       Reacht Weight Loss       Yes         orgina       Yes       No       Easily Winded       Yes       No       Reacht Weight Loss       Yes         orgina       Yes       No       Easily Winded       Yes       No       Realing Easily Winded       Yes       No         ritificial Joint       Yes       No       Easily Winded       Yes       No       Realing Easily Winded       Yes       No         of dot Disease       Yes       No       Easily Winded       Yes       No  | Pregnant/Trying to get pregnant?       Nursing?         you allergic to any of the following?       Penicillin         Aspirin       Penicillin         Metal       Latex         ther?       If         you have, or have you had, any of the following?       If         JDS/HIV Positive       Yes       No         Namphylaxis       Yes       No         Drug Addiction       Yes       No         unamia       Yes       No         Easily Winded       Yes       No         urthritis/Gout       Yes       No         withficial Heart Valve       Yes       No  | Codeine       Acrylic         Sulfa Drugs       Local Anesthetics         yes       Acrylic         Hemophilia       Yes         Hepatitis A       Yes         Hepatitis B or C       Yes         Herpes       Yes         No       Renal Dialysis         Herpes       Yes   |
| Aspirin       Penicilin       Codeine       Arylc         Metal       Latex       Sulfa Drugs       Local Anesthetics         ther?       If yes       Local Anesthetics         vou have, or have you had, any of the following?       Cortisone Medicine       Yes       No         DS/HU Positive       Yes       No       Cortisone Medicine       Yes       No         Idheimer's Disease       Yes       No       Diabetes       Yes       No       Radiation Treatments       Yes         inaph/yakis       Yes       No       Diabetes       Yes       No       Recent Weight Loss       Yes         inaph/skis       Yes       No       Diabetes       Yes       No       Recent Weight Loss       Yes         ingina       Yes       No       Emphysema       Yes       No       Recent Weight Loss       Yes         ingina       Yes       No       Epilepsy or Seizures       Yes       No       Recent Weight Loss       Yes         inficial Heart Valve       Yes       No       Epilepsy or Seizures       Yes       No       Sinde Cell Disease       Yes         iodod Transfusion       Yes       No       Frequent Cough       Yes       No       Sinus Trouble       <  | Aspirin       Penicillin         Metal       Latex         ther?       If         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       If         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medicine         vou have, or have you had, any of the following?       Ortisone Medi   | Sulfa Drugs       Local Anesthetics         yes   |
| Aspirin       Penicillin       Codeine       Arylc         Metal       Latex       Sulfa Drugs       Local Anesthetics         ther?       If yes       Local Anesthetics         cou have, or have you had, any of the following?       Cortisone Medicine       Yes       No         DS/HTV Positive       Yes       No       Cortisone Medicine       Yes       No         Idshimmer's Disease       Yes       No       Diabetes       Yes       No       Radiation Treatments       Yes         naphylaxis       Yes       No       Diabetes       Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Exploration of Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Exploration of Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Exploration of Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Exploration of Yes       No       Recent Weight Loss       Yes         riftical Heart Valve       Yes       No       Exploration of Yes       No       Single Cell Disease       Yes         lobiod Transfusion   | Aspirin       Penicillin         Metal       Latex         ther?       If         you have, or have you had, any of the following?       Cortisone Medicine       Yes         IDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No         Izheimer's Disease       Yes       No       Diabetes       Yes       No         naphylaxis       Yes       No       Drug Addiction       Yes       No         ngina       Yes       No       Emphysema       Yes       No         rthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No         rtfridial Heart Valve       Yes       No       Excessive Bleeding       Yes       No   | Sulfa Drugs       Local Anesthetics         yes   |
| ther?  If yes  to have, or have you had, any of the following?  To have, or have you had, any of the following?  TDS/hTV Positive Yes No Cortisone Medicine Yes No Diabetes Yes No Henophila Yes No Henophila Yes No Recent Weight Loss Yes Yes No Recent Yes No Recent Weight Loss Yes No Recent Weight Loss Yes No Recent Yes No  | ther? If<br>you have, or have you had, any of the following?<br>IDS/HIV Positive OYes No Cortisone Medicine OYes No<br>Izheimer's Disease Yes No Diabetes OYes No<br>naphylaxis OYes No Drug Addiction OYes No<br>nemia OYes No Easily Winded OYes No<br>ngina OYes No Emphysema OYes No<br>rthritis/Gout OYes No Epilepsy or Seizures OYes No<br>rtficial Heart Valve OYes No Excessive Bleeding OYes No   | yes<br>Hemophilia OYes No Radiation Treatments Yes<br>Hepatitis A OYes No Recent Weight Loss Yes<br>Hepatitis B or C OYes No Renal Dialysis OYes<br>Herpes OYes No Rheumatic Fever OYes   |
| Jour have, or have you had, any of the following?         JDS/HUP Positive       Oversione Medicine       Yes       No       Hemophilia       Yes       No       Radiation Treatments       Yes         JDS/HUP Positive       Oversione Medicine       Yes       No       Hemophilia       Yes       No       Radiation Treatments       Yes         JDS/HUP Positive       Oversione       Oversione       Yes       No       Diabetes       Yes       No       Recent Weight Loss       Yes         anaphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Recent Weight Loss       Yes         ngina       Yes       No       Emphysema       Yes       No       Herpes       Yes       No       Recent Weight Loss       Yes         rthrits/Gout       Overs       No       Epilepsy or Seizures       Yes       No       High Blood Pressure       Yes       No       Scartet Fever       Yes         rthficial Heart Valve       Yes       No       Excessive Thirst       Yes       No       Ling Diabestrol       Yes       No       Scartet Fever       Yes         sthma       Overs       No       Frequent Cough       Yes       No   | you have, or have you had, any of the following?<br>IDS/HIV Positive OYes No Cortisone Medicine OYes No<br>Izheimer's Disease OYes No Diabetes OYes No<br>naphylaxis OYes No Drug Addiction OYes No<br>nemia OYes No Easily Winded OYes No<br>ngina OYes No Emphysema OYes No<br>rthritis/Gout OYes No Epilepsy or Seizures OYes No<br>rtficial Heart Valve OYes No Excessive Bleeding OYes No  | Hemophilia       O Yes       No       Radiation Treatments       O Yes         Hepatitis A       O Yes       No       Recent Weight Loss       O Yes         Hepatitis B or C       O Yes       No       Renal Dialysis       O Yes         Herpes       O Yes       No       Renumatic Fever       O Yes   |
| DDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Radiation Treatments       Yes         Lzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Recent Weight Loss       Yes         ngina       Yes       No       Emphysema       Yes       No       Hepatitis B or C       Yes       No       Rheumatic Fever       Yes         rithitis/Gout       Yes       No       Emphysema       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes         rithitis/Gout       Yes       No       Excessive Bleeding       Yes       No       Hives or Rash       Yes       No       Sindle Cell Disease       Yes         olod Disease       Yes       No       Frequent Cough       Yes       No       Hive Problems       Yes       No       Stomach/Intestinal Disease       Yes       No         olod Disease       Yes       No       Frequent Headaches       Yes <td>IDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No         Izheimer's Disease       Yes       No       Diabetes       Yes       No         naphylaxis       Yes       No       Drug Addiction       Yes       No         nemia       Yes       No       Easily Winded       Yes       No         ngina       Yes       No       Emphysema       Yes       No         rthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No         rtificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No</td> <td>Hepatitis A     O Yes     No     Recent Weight Loss     O Yes       Hepatitis B or C     O Yes     No     Renal Dialysis     O Yes       Herpes     O Yes     No     Rheumatic Fever     O Yes</td>   | IDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No         Izheimer's Disease       Yes       No       Diabetes       Yes       No         naphylaxis       Yes       No       Drug Addiction       Yes       No         nemia       Yes       No       Easily Winded       Yes       No         ngina       Yes       No       Emphysema       Yes       No         rthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No         rtificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No   | Hepatitis A     O Yes     No     Recent Weight Loss     O Yes       Hepatitis B or C     O Yes     No     Renal Dialysis     O Yes       Herpes     O Yes     No     Rheumatic Fever     O Yes  |
| DDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No       Hemophilia       Yes       No       Radiation Treatments       Yes         Lzheimer's Disease       Yes       No       Diabetes       Yes       No       Hepatitis A       Yes       No       Recent Weight Loss       Yes         naphylaxis       Yes       No       Easily Winded       Yes       No       Hepatitis B or C       Yes       No       Recent Weight Loss       Yes         ngina       Yes       No       Emphysema       Yes       No       Hepatitis B or C       Yes       No       Rheumatic Fever       Yes         ngina       Yes       No       Emphysema       Yes       No       High Cholesterol       Yes       No       Rheumatism       Yes         rthitis/Gout       Yes       No       Excessive Bleeding       Yes       No       Hives or Rash       Yes       No       Sindle Cell Disease       Yes         load Disease       Yes       No       Frequent Cough       Yes       No       Keer No       Sindle Cell Disease       Yes       No         load Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Keerpholems       Ye   | IDS/HIV Positive       Yes       No       Cortisone Medicine       Yes       No         Izheimer's Disease       Yes       No       Diabetes       Yes       No         unaphylaxis       Yes       No       Drug Addiction       Yes       No         nemia       Yes       No       Easily Winded       Yes       No         ungina       Yes       No       Emphysema       Yes       No         rthritis/Gout       Yes       No       Epilepsy or Seizures       Yes       No         rtificial Heart Valve       Yes       No       Excessive Bleeding       Yes       No   | Hepatitis A     O Yes     No     Recent Weight Loss     O Yes       Hepatitis B or C     O Yes     No     Renal Dialysis     O Yes       Herpes     O Yes     No     Rheumatic Fever     O Yes  |
| naphylaxis       Yes       No       Drug Addiction       Yes       No       Hepatitis B or C       Yes       No       Renal Dialysis       Yes         nemia       Yes       No       Easily Winded       Yes       No       Herpes       Yes       No       Renal Dialysis       Yes         ngina       Yes       No       Emphysema       Yes       No       High Blood Pressure       Yes       No       Rheumatism       Yes         rthrits/Gout       Yes       No       Excessive Bleeding       Yes       No       High Cholesterol       Yes       No       Scarlet Fever       Yes         rthrits/all Joint       Yes       No       Excessive Thirst       Yes       No       Hypoglycemia       Yes       No       Sickle Cell Disease       Yes         sthma       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Sinus Trouble       Yes         lood Disease       Yes       No       Frequent Liarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         lood Transfusion       Yes       No       Frequent Headaches       Yes       No       Leukemia   | naphylaxis OYes No Drug Addiction OYes No<br>nemia OYes No Easily Winded Yes No<br>ngina OYes No Emphysema OYes No<br>rthritis/Gout OYes No Epilepsy or Seizures OYes No<br>rtificial Heart Valve OYes No Excessive Bleeding OYes No  | Hepatitis B or C     O Yes     No     Renal Dialysis     O Yes       Herpes     O Yes     No     Rheumatic Fever     O Yes  |
| nemia Yes No Easily Winded Yes No Herpes Yes No Herpes Yes No Rehumatic Fever Yes Yes No Fringipsema Yes No Emphysema Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes Yes Yes No Excessive Thirst Yes No Excessive The Adaches Yes No Excessive No Erequent Headaches Yes No Excessive No Excessive Theorem Yes No Excessive No Excessive Theorem Yes No Excessive Yes No Excessive No Excessing No Excessive No Excessive No Excess  | nemia OYes No Easily Winded OYes No<br>ngina OYes No Emphysema OYes No<br>rthritis/Gout OYes No<br>rtificial Heart Valve OYes No<br>Excessive Bleeding OYes No  | Herpes OYes ONo Rheumatic Fever OYes  |
| ngina Ves No<br>tritritis/Gout Yes No<br>tritriti  | ngina OYes ONo Emphysema OYes ONo<br>rthritis/Gout OYes ONo Epilepsy or Seizures OYes ONo<br>rtficial Heart Valve OYes ONo Excessive Bleeding OYes ONo  |   |
| rthritis/Gout       \Yes       \No       Epilepsy or Seizures       \Yes       \No       High Cholesterol       \Yes       \No       Scarlet Fever       \Yes       \Yes         rtificial Heart Valve       \Yes       \No       Excessive Bleeding       \Yes       \No       Hives or Rash       \Yes       \No       Shingles       \Yes         rtificial Joint       \Yes       \No       Excessive Thirst       \Yes       \No       Hives or Rash       \Yes       \No       Sickle Cell Disease       \Yes         sthma       \Yes       \No       Fainting Spells/Dizziness       \Yes       \No       Frequent Cough       \Yes       \No       Kidney Problems       \Yes       \No       Sinus Trouble       \Yes         lood Transfusion       \Yes       \No       Frequent Cough       \Yes       \No       Leukemia       \Yes       \No       Stomach/Intestinal Disease       \Yes         ruise Easily       \Yes       \No       Genital Herpes       \Yes       \No       Luwe Disease       \Yes       \No       Swelling of Limbs       \Yes         nacer       \Yes       \No       Galacoma       \Yes       \No       Lung Disease       Yes       \No       Thyroid Disease       Yes       No <td>rthritis/Gout O Yes O No Epilepsy or Seizures O Yes O No<br/>rtificial Heart Valve O Yes O No Excessive Bleeding O Yes O No</td> <td></td>  | rthritis/Gout O Yes O No Epilepsy or Seizures O Yes O No<br>rtificial Heart Valve O Yes O No Excessive Bleeding O Yes O No  |   |
| rtificial Heart Valve Ves No Excessive Bleeding Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Excessive Thirst Yes No Excessive Thirst Yes No Excessive Thirst Yes No Fainting Spells/Dizziness Yes No Fainting Spells/Dizziness Yes No Frequent Cough Yes No Frequent Cough Yes No Frequent Cough Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Frequent Headaches Yes No Excessive Thirst Yes No Frequent Headaches Yes No Frequent Headaches Yes No Genital Herpes Yes No Gaucoma Yes No Eluxer Disease Yes No Stroke Yes No Frequent Attack/Failure Yes No Hay Fever Yes No Hay Fever Yes No Hay Fever Yes No Heart Attack/Failure Yes No Heart Attack/Failure Yes No Steoporosis Yes No Tonsillitis Yes No Stroke Yes No Stroke Yes No Store Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Yes No Yes Yes No Heart Northol Disease Yes No Yes No Yes Yes No Heart Northol Disease Yes No Yes No Heart Northol Disease Yes No Yes No Heart Northol Disease Yes No Yes No Yes Yes No Yes Yes No Heart Northol Disease Yes No Yes No Yes Yes No Heart Northol Disease Yes No Yes No Yes Yes No Yes Yes No Heart Northol Disease Yes No Yes No Yes   | rtificial Heart Valve O Yes O No Excessive Bleeding O Yes O No  | Thigh blood messare Ones Only Indicatination Ones   |
| Initial Joint       Yes       No       Excessive Thirst       Yes       No       Hypoglycemia       Yes       No       Sickle Cell Disease       Yes       No         sthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sickle Cell Disease       Yes       No         lood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifida       Yes         lood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         nuise Easily       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stomach/Intestinal Disease       Yes         nuise Easily       Yes       No       Genital Herpes       Yes       No       Lung Disease       Yes       No       Stomach/Intestinal Disease       Yes         nuise Easily       Yes       No       Gaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         hemotherapy       Yes       No       <  |   | High Cholesterol OYes ONo Scarlet Fever OYes  |
| sthma       Yes       No       Fainting Spells/Dizziness       Yes       No       Irregular Heartbeat       Yes       No       Sinus Trouble       Yes         lood Disease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifida       Yes         lood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         ruse Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         ancer       Yes       No       Gaucoma       Yes       No       Gaucoma       Yes       No       Diver Disease       Yes       No       Swelling of Limbs       Yes         hemotherapy       Yes       No       Hay Fever       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         onvulsions       Yes       No       He   |   | Hives or Rash O Yes O No Shingles O Yes   |
| Image: Solution of the second bisease       Yes       No       Frequent Cough       Yes       No       Kidney Problems       Yes       No       Spina Bifida       Yes         Image: Solution of transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         ruise Easily       Yes       No       Frequent Headaches       Yes       No       Eukemia       Yes       No       Stomach/Intestinal Disease       Yes         ancer       Yes       No       Galaucoma       Yes       No       Biolod Pressure       Yes       No       Swelling of Limbs       Yes         hemotherapy       Yes       No       Galaucoma       Yes       No       Mitral Valve Prolapse       Yes       No       Torsillitis       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Parethyroid Disease       Yes       No       Tumors or Growths       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       Pres       Pres         we you ever had any serious illness not listed above?       Ores       No       If yes       If yes <td>rtificial Joint O Yes O No Excessive Thirst O Yes O No</td> <td>Hypoglycemia OYes ONo Sickle Cell Disease OYes</td>  | rtificial Joint O Yes O No Excessive Thirst O Yes O No  | Hypoglycemia OYes ONo Sickle Cell Disease OYes  |
| Nood Transfusion       Yes       No       Frequent Diarrhea       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         reathing Problems       Yes       No       Frequent Headaches       Yes       No       Leukemia       Yes       No       Stomach/Intestinal Disease       Yes         ruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Stoke       Yes         cancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         chemotherapy       Yes       No       Heart Attack/Failure       Yes       No       Heart Attack/Failure       Yes       No       Tuberculosis       Yes         clod Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Heart Trouble/Disease       Yes       No       Tumors or Growths       Yes         convulsions       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Parathyroid Disease       Yes       No       Yes       Yes         ave you ever had any serious illness not listed above?       Yes   | sthma OYes ONo Fainting Spells/Dizziness OYes ONo   | Irregular Heartbeat O Yes O No Sinus Trouble O Yes  |
| reathing Problems       Yes       No       Frequent Headaches       Yes       No       Liver Disease       Yes       No       Stroke       Yes         ruise Easily       Yes       No       Genital Herpes       Yes       No       Liver Disease       Yes       No       Stroke       Yes         ancer       Yes       No       Glaucoma       Yes       No       Hay Fever       Yes       No       Hitral Valve Prolapse       Yes       No       Tonsillitis       Yes         hest Pains       Yes       No       Heart Attack/Failure       Yes       No       Heart Murmur       Yes       Osteoporosis       Yes       No       Tumors or Growths       Yes         old Sores/Fever Blisters       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Yes       Yes         ave you ever had any serious illness not listed above?       Yes       No       If yes       If yes       Yes       Yes   | lood Disease OYes ONo Frequent Cough OYes ONo   | Kidney Problems O Yes O No Spina Bifida O Yes   |
| ruise Easily       Yes       No       Genital Herpes       Yes       No       Low Blood Pressure       Yes       No       Swelling of Limbs       Yes         ancer       Yes       No       Glaucoma       Yes       No       Low Blood Pressure       Yes       No       Thyroid Disease       Yes       Yes         hemotherapy       Yes       No       Hay Fever       Yes       No       Hurg Disease       Yes       No       Tonsillitis       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         ongenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Yes       Yes       Yes         we you ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       Image: State Sta   | lood Transfusion O Yes O No Frequent Diarrhea O Yes O No  | Leukemia OYes ONo Stomach/Intestinal Disease OYes   |
| ancer       Yes       No       Glaucoma       Yes       No       Lung Disease       Yes       No       Thyroid Disease       Yes         hemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsillitis       Yes         hest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         ongenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Yes       Yes       Yes         we you ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       If yes       Image: State of the   | reathing Problems OYes ONo Frequent Headaches OYes ONo  | Liver Disease OYes ONo Stroke OYes  |
| hemotherapy       Yes       No       Hay Fever       Yes       No       Mitral Valve Prolapse       Yes       No       Tonsilitis       Yes         hest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         ongenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       If yes       Yes       Yes         we you ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       If yes  | ruise Easily O Yes O No Genital Herpes O Yes O No   | Low Blood Pressure O Yes O No Swelling of Limbs O Yes   |
| hest Pains       Yes       No       Heart Attack/Failure       Yes       No       Osteoporosis       Yes       No       Tuberculosis       Yes       Yes         old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes       Yes         ongenital Heart Disorder       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       Yes       Yes       Yes       Yes         ave you ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       If yes  | ancer OYes ONo Glaucoma OYes ONo  | Lung Disease O Yes O No Thyroid Disease O Yes   |
| old Sores/Fever Blisters       Yes       No       Heart Murmur       Yes       No       Pain in Jaw Joints       Yes       No       Tumors or Growths       Yes         ongenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Pain in Jaw Joints       Yes       No       Ulcers       Yes       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       Psychiatric Care       Yes       No       Venereal Disease       Yes         ave you ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       If yes   | hemotherapy OYes ONo Hay Fever OYes ONo   | Mitral Valve Prolapse O Yes O No Tonsillitis O Yes  |
| ongenital Heart Disorder       Yes       No       Heart Pacemaker       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       Yes         onvulsions       Yes       No       Heart Trouble/Disease       Yes       No       Parathyroid Disease       Yes       No       Ulcers       Yes       Yes         very ou ever had any serious illness not listed above?       Yes       No       If yes       If yes       If yes       If yes   | hest Pains OYes ONo Heart Attack/Failure OYes ONo   | Osteoporosis OYes ONo Tuberculosis OYes   |
| onvulsions O Yes O No Heart Trouble/Disease O Yes O No Psychiatric Care O Yes O No Venereal Disease O Yes O   | old Sores/Fever Blisters O Yes O No Heart Murmur O Yes O No   | Pain in Jaw Joints OYes ONo Tumors or Growths OYes  |
| ave you ever had any serious illness not listed above? Ores ONo If yes  | Congenital Heart Disorder 🔿 Yes 🔿 No 🛛 Heart Pacemaker 🔗 Yes 🔿 No   | Parathyroid Disease O Yes O No Ulcers O Yes   |
|   | onvulsions O Yes O No Heart Trouble/Disease O Yes O No  |   |
| ments:  | I<br>ve you ever had any serious illness not listed above? O Yes O No If  | yes   |
|   | ments:  |   |
|   | Comments:   |   |

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## **Appointment Cancellation Policy**

At Watermark Dental, the time scheduled for your dental appointment is yours alone. We only double book for emergency appointments. Consequently, when an appointment is canceled, especially at the last minute, our entire practice is affected. We understand that cancellations are sometimes unavoidable, but the scheduling time lost is costly to any practice.

We utilize emails and text messaging to remind you of upcoming appointments. A reminder is sent two weeks prior to your appointment so that you may choose to reschedule if needed. And on the day before your appointment, an additional email and/or text message is sent, allowing you to confirm the appointment by email or a return text message response.

Since we schedule our routine exams and cleanings six months in advance, it can be difficult to reschedule an appointment on short notice. We strive to provide the very best dental care to all of our patients and ask that you make changes to your appointments dates as soon as practical.

We value your time...please offer the same respect by giving at least one full business day of advanced notice when you need to cancel an appointment so that we can offer that time to other patients.

Because of the costs involved in having the appointment time available for you, there is a missed appointment charge of \$45 per forty-five minutes of appointment time scheduled, if we do not receive that advanced notice and you miss your appointment or arrive too late to be seen for a scheduled appointment. Any charges must be paid prior to scheduling the next appointment.

## **Financial Responsibility**

It is the patient's responsibility to know what their insurance will or will not cover. By signing this disclaimer, I accept responsibility for payment of any and all expenses that are not covered by benefits of my insurance. I agree that, if for any reason, my insurance company fails to reimburse any portion of a claim for services at this office it is my responsibility to pay what is owed to Watermark Dental. Please note that quotes obtained for services are not a guarantee of coverage. Copays are due at the time of service.

## Authorization to submit insurance claims

I authorize Watermark Dental to submit my insurance claims for payment of services rendered to me. This includes submission of x-rays, treatment notes or any other information requested by my insurance company.

| I have read the Appointment Cancellation Policy, Financial Responsibility and Authorization to Submit<br>Insurance Claims, and agree to the terms outlined above. |
|---|
| Printed name:   |
| Sigature:   |
| Date:   |
|   |

| Watermark<br>Dental<br>Excellence in Contemporary Dentistry                              | Jason T. Culley, D.D.S.<br>1225 Dublin Road<br>Columbus, OH 43215<br>(614) 488-9050<br>9745 Fairway Dr.<br>Powell, OH 43065<br>(614) 766-5722 |
|--|---|
|  |   |
| Patient Name:  | Birthdate:  |
| Other Family members to transfer:  |   |
|  |   |
| Previous Dentist or Practice Name:   |   |
| Address:   |   |
| Phone: Fax:  | E-mail:   |
| Please forward the following information:  |   |
| <ul> <li>Bitewings and/or Panorex</li> <li>PA's</li> <li>Periodontal charting</li> </ul> | <ul> <li>Charting</li> <li>Photographs</li> <li>Other:</li> </ul>   |
|  | □ Other:  |
| I hereby give my permission to release any and all den                                   | tal records to Watermark Dental. I also release the   |
| practice and staff of  | from any laws related to disclosure of  |
| confidential or privileged information.  |   |
| Patient Signature:   |   |

Please send completed forms to: infowatermarkdental@gmail.com