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Patient Name:	Patient Information			,	(Office Use) Chart #			
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Have your ever had any o ☐ AIDS Allergies:	☐ Excessive Bleed ☐ Fainting ☐ Glaucoma ☐ Growths	ding	k those that apply. ☐ Kidney Disease ☐ Liver Disease ☐ Mental Disorders ☐ Mitral Valve Prolaps		ose	☐ Tum ☐ Ulce	Venereal Disease	easė
☐ Penicillin ☐ Codeine ☐ Anemia ☐ Artificial Joints ☐ Asthma ☐ Blood Disease ☐ Cancer ☐ Congestive Heart ☐ Diabetes ☐ Dizziness ☐ Epilepsy • Have you ever had any colf yes, please explain: ☐ Have you been admitted to If yes, please explain: ☐ Are you now under the care	☐ Hay Fever ☐ Head Injuries ☐ Heart surgery ☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis ☐ HepatitisB ☐ High Blood Pres ☐ HIV+ ☐ Jaundice ☐ Joint replacement ☐ a hospital or needence of a physician?	ssure nt/pins g dental tre ed emerge	□ Nervous □ Pacemake □ Pregnance □ Pregnance □ Radiation □ Respirator □ Rheumatis □ Rheumatis □ Sinus Prol □ Stomach F □ Stroke eatment? □ ncy care duri	Treatment of the problem of the prob	ent ems No ast two	pre	Medications sently tal	n(s) king:
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Name of Physician:					Phoi	ne:	***************************************	, , , , , , , , , , , , , , , , , , ,
Do you have any health pro If yes, please explain:								
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.								
Signature of patient, parent or gu					D	ate:		
Signature of patient, parent or gu	ardian	A A A A A A A A A A A A A A A A A A A		-				
Referral Information								
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