



1 1 4 0 0 0 0 0 R E G 0 0 1

Print patient ID No. in boxes at left (located on ID card, if applic.)
DEPENDENT INFORMATION

Name (First, Last)

Email address

Date of Birth (MM/DD/YYYY) Male
 Female

Address (please do not use P.O. Box)

City State ZIP Code

Daytime Phone Evening Phone
 () ()

ALLERGIES:
 32-Codeine 87-Sulfa Other (list):
 70-Penicillin 93-Tetracycline

HEALTH CONDITIONS:
 200-Diabetes 600-Stomach Disorders
 300-Hypertension 700-Thyroid Disease
 400-Heart Disease 800-Arthritis
 500-Glaucoma Other (list):

Check if prescription(s) enclosed for this patient and print:
 Dr. Name Dr. Phone (very important)
 ()

Check if this patient needs snap-on caps.

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