PATIENT INFORMATION

ADULT

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____ SS# _____
FIRST MI LAST

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ HOME PHONE _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED ❑

PATIENT ❑
PARENT ❑ EMPLOYER _____ WORK PHONE _____
GUARDIAN ❑

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE ❑
PARENT ❑ NAME _____ SS# _____
GUARDIAN ❑

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK NO. _____

EMERGENCY CONTACT _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____ WORK PHONE _____

SS# _____ DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES ❑ NO ❑

DENTAL INSURANCE INFORMATION

COPY OF INSURANCE CARD OBTAINED? YES ❑ NO ❑
COPY OF DRIVER'S LICENSE OBTAINED? YES ❑ NO ❑

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

BIRTHDATE _____ SS# _____ ID NUMBER _____

IF PATIENT IS DEPENDENT AND COLLEGE STUDENT, NAME AND ADDRRESS OF COLLEGE: _____

_____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE ? YES ❑ NO ❑ IF YES, COMPLETE THE FOLLOWING:

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

BIRTHDATE _____ SS# _____ ID NUMBER _____

PATIENT DENTAL HISTORY

PREVIOUS DENTIST NAME _____ PH# _____ LAST VISIT _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ PH# _____ DATE OF LAST EXAM _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. ARE YOU TAKING BLOOD THINNERS?	☐	☐
IF YES, WHAT KIND? _____		
5. ARE YOU TAKING ANY BISPHOSPHONATES, SUCH AS: BONIVA, ACTONEL, OR FOSAMAX?	☐	☐

	YES	NO
6. DO YOU USE TOBACCO?	☐	☐
7. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?**

	YES	NO
ASPIRIN	☐	☐
NSAIDS/NARCOTICS	☐	☐
IODINE	☐	☐
LATEX	☐	☐
LOCAL ANESTHETICS	☐	☐
PENICILLIN	☐	☐
SEDATIVES/BARBITUATES	☐	☐
SULFA DRUGS	☐	☐
OTHER	☐	☐

_____

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. MEDICAL CONDITIONS - PAST OR PRESENT:

	YES	NO
AIDS / HIV INFECTION	☐	☐
ARTHRITIS	☐	☐
ASTHMA	☐	☐
BLOOD PRESSURE	☐	☐
HIGH	☐	☐
LOW	☐	☐
STROKE	☐	☐
CANCER	☐	☐
CHEMOTHERAPY	☐	☐
LEUKEMIA	☐	☐
RADIATION THERAPY	☐	☐
TYPE_____	☐	☐
DIABETES	☐	☐
EPILEPSY/SEIZURES	☐	☐
GLAUCOMA	☐	☐
HAY FEVER / ALLERGIES	☐	☐

	YES	NO
HEART PROBLEMS	☐	☐
BY-PASS SURGERY	☐	☐
CARDIAC PACEMAKER	☐	☐
CHEST PAINS	☐	☐
CONGESTIVE HEART FAILURE	☐	☐
HEART MURMUR	☐	☐
HIGH CHOLESTEROL	☐	☐
IRREGULAR HEARTBEAT	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
STENTS	☐	☐
JOINT REPLACEMENT / IMPLANT	☐	☐
KIDNEY DISEASE	☐	☐
LIVER DISEASE	☐	☐
HEPATITIS / JAUNDICE	☐	☐
TYPE_____	☐	☐

	YES	NO
LUNG PROBLEMS	☐	☐
COPD	☐	☐
EMPHYSEMA	☐	☐
OSTEOPOROSIS	☐	☐
OSTEOARTHRITIS	☐	☐
RHEUMATIC FEVER	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
STOMACH TROUBLE	☐	☐
ULCERS	☐	☐
ACID REFLUX	☐	☐
SWOLLEN ANKLES	☐	☐
THYROID DISEASE	☐	☐
TUBERCULOSIS	☐	☐
OTHER	☐	☐

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE DENTAL ARTS OF CORINTH, PLLC TO VERIFY MY EMPLOYMENT. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ _____

SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF MINOR DATE