

## PATIENT INFORMATION

Miss  Ms.  Mrs.  Mr.  Dr.  Sr.  Jr. Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I prefer to receive phone calls at:  Home  Business  Cell

Email Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  M  F

If Student, Name of School/College: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Patient or Parent/Guardian Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_

How did you hear about our office?  Online  Newspaper  Patient  Phonebook Ad

If referred by a patient, what is the patient's name? \_\_\_\_\_

### Responsible Party:

Name of Person Responsible for the Account: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Is this Person Currently a Patient at Our Office?  Y  N

### Insurance Information:

Name of Insurance Subscriber: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Insurance Identification #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

### Additional Insurance:

Name of Insurance Subscriber: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Insurance Identification #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_



## Medical History

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Your last physical examination was on \_\_\_\_\_

Please check any of the following that you are allergic to:

Latex    Codeine    Dental Anesthetics    Penicillin    Sulfa Drugs    Other

Are you allergic to any other antibiotics?  Yes  No Please list: \_\_\_\_\_

Do you need to pre-medicate prior to dental appointments?  Yes  No If yes, please explain:

\_\_\_\_\_

List all medications that you are currently taking, and include the reason(s) why: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you taking any of the following?

Antibiotics or sulfa drug	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulants (blood thinners)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antihistamines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone (steroids)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis or drugs for the heart	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral contraceptives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hormone Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you use recreational drugs?  Yes  No

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you use chewing tobacco?  Yes  No How much? \_\_\_\_\_

Are you pregnant or possibly pregnant?  Yes  No Are you nursing?  Yes  No

Have you had any serious illness or operation?  Yes  No

If so, what was the illness or operation? \_\_\_\_\_

Have you been hospitalized or had a serious illness within the last 5 years?  Yes  No

If so, what was the problem? \_\_\_\_\_

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectorus	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sub-bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Transplants	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>			
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Immuno compromised	<input type="checkbox"/>	<input type="checkbox"/>			

Diseases or problems not listed:

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### Dental History

Do you experience any of the following:

	Yes	No		Yes	No
Bleeding while flossing or brushing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to hot or cold	<input type="checkbox"/>	<input type="checkbox"/>	Clenching or grinding your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweet or sour foods	<input type="checkbox"/>	<input type="checkbox"/>	Head, Neck or Jaw injuries	<input type="checkbox"/>	<input type="checkbox"/>
Pain in any of your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sores or lumps in or near mouth	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ear, side of face, joint	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening/closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Problems not listed:

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Have you had abnormal bleeding with previous extractions, surgery or trauma?  Yes  No

Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?  Yes  No

Chief reason for making this dental appointment: \_\_\_\_\_

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Have you been told by your previous dentist that you have a major dental problem:  Yes  No

If so, what is the problem: \_\_\_\_\_

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*I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/ her staff, responsible for any errors or omissions that I may have made in the completion of this form.*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Dentist

### Consent for Treatment

I hereby authorize the dentist to administer and perform the necessary procedures such as; x-rays, photographs, models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental condition.

I authorize the dentist to perform all recommended treatment **mutually agreed upon** by me and to use the appropriate medication and therapy indicated for such treatment in connection with me. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit in order to provide the recommended treatment.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## Insurance Consent

I authorize the dentist to release all information necessary to secure the payment of insurance benefits. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## Financial Policy

- Payment in full is due at the time of treatment, unless prior arrangements have been made.
- As a courtesy to our patients, we will gladly fill out your insurance form for you. You will be responsible for mailing in the insurance form.
- For procedures totaling \$500 or more, we offer a 5% discount when you pay in full by cash or check on or before the date the service is initiated. We offer a 3% discount when you pay in full by credit or debit card on or before the date the service is initiated.
- We accept Cash, Check, Visa, Mastercard, Discover and American Express.
- For patients who qualify, we offer a variety of payment plans through a third party financing company called CareCredit. There are no upfront costs, prepayment penalties or annual fees to our patients.

I agree to the above stated financial policy.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Corning Dental Associates RLLP**

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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*\*\*You may refuse to sign this agreement\*\**

I, \_\_\_\_\_ have received a copy of Corning Dental Associates Notice of Privacy Practices.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify)

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