CORSA ORTHODONTICS

Dr. Christopher Corsa, DMD, MS

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1 Patient Information

Name ______________________________ Sex M F
Last First Middle

Address ______________________________
Street City State Zip

Birthdate ____/____/____ Age ________ Email ______________________________
MM DD YYYY

Home Phone ____________ General Dentist ____________ Last Visited ____________

Whom may we thank for referring you to our office ______________________________

2 Parents Information

☐ **FATHER** ☐ **STEPFATHER** ☐ **GUARDIAN**

Name ______________________________ Marital Status ____________
Last First Middle

Address ______________________________
Street City State Zip

Birthdate ____/____/____ Email ____________ Social Security # ____________
MM DD YYYY 999-99-9999

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Ext. ______
999-999-9999 999-999-9999 999-999-9999

Employer ____________ Occupation ____________ No. Years Employed ________

☐ **MOTHER** ☐ **STEPMOTHER** ☐ **GUARDAIN**

Name ______________________________ Marital Status ____________
Last First Middle

Address ______________________________
Street City State Zip

Birthdate ____/____/____ Email ____________ Social Security # ____________
MM DD YYYY 999-99-9999

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Ext. ______
999-999-9999 999-999-9999 999-999-9999

Employer ____________ Occupation ____________ No. Years Employed ________

3 Insurance Information

Policy Owner's Name ____________ Policy Owner's Employer ____________

Insurance Company ____________ Group No. (plan, local, or policy) ____________

Insurance Co. Address ____________ Insurance Phone # ____________

Do you have dual coverage? Y N

4 General Information

School ______________________________ Brothers/Sister (include ages): ______________________________

Hobbies: ____

____

____

5 Medical History

Yes	No	Artificial Joint/Valves	Yes	No	High Blood Pressure	Yes	No	Pregnant
Yes	No	Automobile/Sports Injury	Yes	No	HIV	Yes	No	Sleep Apnea
Yes	No	Cancer/Chemotherapy	Yes	No	Hospitalization for Any Reason	Yes	No	Stroke/Heart Attack
Yes	No	Heart Defects/Murmur	Yes	No	Loud Snoring	Yes	No	Thyroid Problem
Yes	No	Diabetes	Yes	No	Radiation Treatment	Yes	No	Tobacco Use
Yes	No	Frequent Headaches	Yes	No	Fomax/Bisphoshonate (Osteoporosis)	Yes	No	Tuberculosis (TB)
Yes	No	Hepatitis	Yes	No	Ringing in Your Ears/Earaches	Yes	No	Others: ____________

Any known Allergies: ____

Medication(s): ____

GENERAL DENTIST:

Any serious/difficult problem associated with any dental treatment before? Yes No

Any joint pain/clicking/problem (TMJ/TMD)? Yes No

Are you aware of teeth grinding at night/during the day? Yes No

Are you a mouth breather? Yes No

Any problem with dental restorations failures? Yes No

Have you had evaluation before? Yes No

If so, what question(s) do you have? ____

Rank order of importance of treatment: Result ______ Service ______ Price ______

Main concern that you want to resolve by this treatment: ____

____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form ______________________________ Date ______________