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 _____ Social Security # _____
MM DD YYYY 999-99-9999

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Whom may we thank for referring you to our office _____

2 Spouse/Additional Contact Information

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

PRIMARY

Policy Owner's Name _____ Policy Owner's Social Security # _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

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

Insurance Company's Address _____ Insurance Phone No. _____

SECONDARY

Policy Owner's Name _____ Policy Owner's Social Security # _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

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

Insurance Company's Address _____ Insurance Phone No. _____

4 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 _____