



CORA ORTHODONTICS

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Patient Information

Name _____ Sex M F
Last First Middle

Address _____
Street City State Zip

Birthdate / / Age Email _____
MM DD YYYY

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

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Whom may we thank for referring you to our office _____

Hobbies, Interests, and Things that you love _____

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Spouse/Additional Contact Information

Name _____ Relationship to patient _____
Last First Middle

Address _____ Same as above
Street City State Zip

Birthdate / / Email _____
MM DD YYYY

Home Phone _____ Cell Phone _____ Cell Phone Provider _____
999.999.9999 999.999.9999 999.999.9999

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Insurance Information

PRIMARY

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

Policy Owner's Birthdate / / Relationship to Patient _____
MM DD YYYY

Policy Owner's Employer _____

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

Insurance Company's Address _____ Insurance Phone No. _____

Do you have dual coverage? Y N

SECONDARY

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

Policy Owner's Birthdate / / Relationship to Patient _____
MM DD YYYY

Policy Owner's Employer _____ Employer's Address _____

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

Insurance Company's Address _____ Insurance Phone No. _____

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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): _____

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 (1 being the top priority) _____ 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 _____