CORSA ORTHODONTICS

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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 _____

School _____

Brothers/Sisters (include ages) _____

Hobbies, Interests, and Things that you love _____

2 Parents Information

☐ FATHER ☐ STEPFATHER ☐ GUARDIAN

Name _____ Marital Status _____
Last First Middle

Address _____ ☐ Same as above
Street City State Zip

Birthdate ___/___/___ Email _____
MM DD YYYY

Home Phone _____ Cell Phone _____ Cell Phone Provider _____ Work Phone _____ Ext. _____
999-999-9999 999-999-9999 999-999-9999

Employer _____ Occupation _____ No. Years Employed _____

☐ MOTHER ☐ STEPMOTHER ☐ GUARDIAN

Name _____ Marital Status _____
Last First Middle

Address _____ ☐ Same as above
Street City State Zip

Birthdate ___/___/___ Email _____
MM DD YYYY

Home Phone _____ Cell Phone _____ Cell Phone Provider _____ 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 _____

Policy Owner's Social Security # _____

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

Insurance Co. Address _____ Insurance Phone # _____

Do you have dual coverage? Y ☐ N ☐

SECONDARY

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

Policy Owner's Birthdate ___/___/___ (MM DD YYYY) 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): _____

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 _____

Submit