Welcome to Corbin Family Dental Care

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

Today's Date: _____

Patient's Name _____ **Sex: M F Birthdate:** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

SS #: _____ **Marital Status:** _____ **Text: Y / N**

Employer: _____ **Occupation:** _____ **E-Mail:** _____

Who may we thank for referring you? (circle all that apply)

Patient: _____ **Dr.:** _____ **Smile Card-Given by:** _____

Yellow Pages Walk In or Sign Insurance Company Direct Mail Internet Facebook Billboard

MEDICAL INFORMATION

Do you have any CURRENT HEALTH PROBLEMS?	Yes	No
Are you under a PHYSICIAN'S CARE now?	Yes	No
Do you smoke?	Yes	No
Do you use smokeless tobacco?	Yes	No
Are you pregnant?	Yes	No

Family Physician: _____

Physician #: _____

Have you ever taken medications for osteoporosis? Yes No If yes, what?

_____

Circle any of the following that you HAVE or have HAD:

Heart Failure	Anemia	Kidney Trouble
Heart Disease	Stroke	High Blood Pressure
Heart Surgery	AIDS or HIV+	Hepatitis A / B / C
Mitral Valve Prolapse	Asthma	Artificial Joint (Hip, Knee)
Heart Pacemaker	Ulcers	Hepatitis B (serum)
Artificial Heart Valve	GERD	Yellow Jaundice
Angina Pectoris	Diabetes	Blood Transfusion
Heart Attack	Glaucoma	Epilepsy or Seizures
Chemotherapy	Heart Murmur	Fainting or Dizzy Spells
Radiation Treatment	Alcoholism	Psychiatric Treatment
Liver Disease	Drug Addiction	Cosmetic Surgery
Venereal Disease	Sinus Trouble	Rheumatism/Arthritis
Rheumatic Fever	Emphysema	Bleeding Problems
Restless Leg Syndrome	COPD	Chronic Bronchitis
Thyroid Disease	Frequent Headaches	Cancer

Sleep Apnea Y / N

If yes, do you sleep with a CPAP/BiPap? Y / N

Do you have any other medical or dental condition not listed or you feel I should know about?

_____

_____

Are you aware of any other allergic or adverse reaction to any meds not listed?

_____

Have you ever had an allergic or adverse reaction to any of the following medications?

Aspirin	Percocet	Erythromycin
Darvon	Codeine	Local Anesthetic
Valium	Penicillin	Nitrous Oxide
Latex	Adhesives	Metals

LIST OF CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy:

_____

KATHERINE L. WHITAKER, DMD
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

I, _____, have received a copy of this office's Notice of Privacy Practices. I further authorize Katherine L. Whitaker, DMD to release information to schools and employers concerning my appointments scheduled.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please specify)

_____

_____

_____

Emergency Contact

Name of nearest relative not living with you: _____ Relationship: _____

Complete Address: _____ Phone: _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I understand where appropriate, credit bureau reports may be obtained.

Signature _____ Date: _____

(Adult Patient or Parent of Minor Child)

CORBIN FAMILY DENTAL CARE
FINANCIAL POLICY
PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE

In the effort to hold costs down, payment is due when services are rendered. You may apply for a payment plan through our preferred financial agencies, which must be arranged and approved in advance of your appointment. Credit Bureau reports may be obtained to facilitate this, where appropriate.

As a courtesy to our patients who have Dental Insurance coverage, we will be happy to file your claim electronically. Your estimated portion (deductible and/or co-pay) is due in full at the time of service. We will figure these amounts for you using the information provided by your plan. Any amount exceeding your annual maximum is due when your service is rendered. In the event your insurance claim is not processed in a timely manner, we will file the claim a second time. However, further delays caused by the insurance company resulting in payment past 60 days, will require you to make full payment to our office. Any payment/overpayment received from you insurance company will be reimbursed to you once your total account balance has been resolved. To expedite processing, you will need to contact the insurance company directly.

Any insurance benefits you have are an independent contract between you and your carrier. **You are ultimately responsible for any balance not paid by the insurance company.** In addition, you are responsible for keeping us informed of your insurance status so that we may file for and obtain your insurance benefits in a timely manner.

If you are unable to make any scheduled appointment, it is important that you call our office as soon as possible so that we can make other arrangements. We require notification a minimum of two business days in advance so that we may accommodate another patient. **Cancellation within 24 hours may result in a penalty.**

Delinquent accounts are processed for collections following the guidelines of the Fair Debt Collection Practices Act. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls, including auto dialed calls and prerecorded messages at that wireless number from Corbin Family Dental Care, it successors and assigns, and the affiliates, agents and independent contractors, including servers and collection agents, of each of them regarding the services rendered, or my related financial obligations. I understand that all reasonable collection costs/attorney fees on any past due amounts will be my responsibility. Returned checks will be assessed a $30 NSF fee.

I have read, understand, and agree to the above FINANCIAL AGREEMENT, if applicable, I assign my insurance benefits to be payable to Corbin Family Dental Care.

_____ _____

Signature Date

CORBIN
FAMILY
DENTAL
CARE

I give permission for Corbin Family Dental Care to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. (check all boxes that apply) This form does not authorize releasing copies of my records.

☐ Scheduling/Appointment information

☐ Billing and payment information

☐ Dental record information

Corbin Family Dental Care has my permission to discuss the above information with the following family, friends and/or other persons. This information is directly relevant to their involvement in my dental care (or payment of that care).

Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

I understand that in certain situations Corbin Family Dental Care may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time. I understand this permission remains in effect until the time I revoke it in writing.

Signature of Patient/Authorized Representative **X** _____

Date: _____