

# 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 Family Physician: \_\_\_\_\_  
Are you under a PHYSICIAN'S CARE now? Yes No Physician #: \_\_\_\_\_  
Do you smoke? Yes No Have you ever taken medications for  
Do you use smokeless tobacco? Yes No osteoporosis? Yes No If yes, what?  
Are you pregnant? Yes No \_\_\_\_\_

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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## Emergency Contact

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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)

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## 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, its 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