Aris Corkos, D.D.S.

Patient Information

Personal Information

Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone _____ Wireless Phone _____

Email _____ Wireless Carrier _____

Preferred Contact Method [ ] Wireless Phone [ ] Email [ ] Home Phone [ ] Work Phone

Student Status if Dependent over 19 (for Ins) [ ] Non-Student [ ] Full Time [ ] Part Time

How did you hear about us? _____

(If someone referred you, please write down their name so we can thank them)

Address and Home Phone

Check box if same for entire family [ ]

Address _____

Address 2 _____

City _____ State _____ Zip _____

Home Phone _____

Insurance Policy 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber ID# _____

Subscriber Name _____ Subscriber Date of Birth _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

Please present insurance card to receptionist

Insurance Policy 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber ID# _____

Subscriber Name _____ Subscriber Date of Birth _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

I give my consent to Dr. Corkos and staff to contact me on my mobile phone and by email for appointments, insurance and account related matters.

I authorize Aris Corkos, D.D.S., to furnish any necessary information to my insurance companies, and I authorize my insurance companies to pay Aris Corkos, D.D.S., directly.

I understand that I myself am responsible for all fees incurred, and that my insurance claims are processed by this office as a courtesy to me. I also understand that fees quoted to me are subject to increase if the accepted treatment is not completed, for any reason, within the recommended time frame.

_____ _____

Signature (parent/guardian if patient is a minor) Date

Aris Corkos, D.D.S.

Patient Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Physician Name: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications you are now taking:

[ ] None

List all allergies, including drug allergies:

[ ] None [ ] Latex Allergy [ ] Penicillin Allergy [ ] Epinephrine Allergy

[ ] Other:

Circle any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pacemaker, pregnancy, psychiatric treatment, sinus trouble, stroke, surgeries, ulcers, history of rheumatic fever, or history of taking fen-phen:
[ ] None [ ] Other:

Reason for today's visit _____ **Are you in pain?** _____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Do you require antibiotic premedication for dental appointments? _____

New patients:

Do you have Full Mouth or Panoramic x-rays that are less than 5 years old? _____ Approx. Date: _____

Do you have Bite Wing x-rays that are less than 1 year old? _____ Approx. Date: _____

Name of former Dentist _____ City/State _____

Date of last cleaning and exam _____

Authorization and Release

I certify that the above information is true. I consent to any dental procedures, including x-rays and local anesthetics, that are deemed necessary for proper diagnosis and treatment.

Regarding HIPAA: I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I acknowledge that I have received the Dental Materials fact Sheet that was updated on May 14, 2004.

_____ _____

Signature of patient (parent or guardian if patient is a minor) Date