CORNER CANYON Dentistry

PATIENT INFORMATION

Date: _____
Patient's Name: _____ Birth date: _____ Age: _____
Address: _____ City: _____ Zip Code: _____
Sex (Circle): **M F** Social Security # _____ Email Address: _____
Home Phone # _____ Business # _____ Cell # _____
Patient's Employer: _____ Marital Status (Circle): **Married Single**
Is patient a full time student? **Y N** Name of School: _____
Spouse's Name: _____ Spouse's Soc Sec # _____
Person to contact in case of an emergency: _____
Address: _____ Phone # _____
Relationship: _____ Referred by: _____

GUARANTOR INFORMATION

Name of responsible party: _____ Relationship: _____
Address: _____ City: _____ Zip Code: _____
Home Phone # _____ Social Security # _____
Employer: _____
Employer's Address: _____ City: _____ Zip Code: _____
Business Phone # _____
Will dental insurance be involved? _____

PATIENT INSURANCE INFORMATION

Subscriber's Name: _____ Social Security # _____
Relationship to the Subscriber (Circle): **Self Spouse Child Other**
Name of Insurance Company: _____ Subscriber ID# _____
Insurance Address: _____ Subscriber DOB: _____
Phone # _____ Group # _____

SECONDARY INSURANCE

Subscriber's Name: _____ Social Security # _____
Relationship to the Subscriber (Circle): **Self Spouse Child Other**
Name of Insurance Company: _____ Subscriber ID# _____
Insurance Address: _____ Subscriber DOB: _____
Phone # _____ Group # _____

Because everyone deserves a beautiful smile.

NEW PATIENT FORM CONTINUED...

DENTAL/MEDICAL HISTORY (Confidential)

HEALTH INFORMATION Please indicate YES or NO			Please indicate YES or NO		
Are you in good health	___	___	Abnormal blood pressure	___	___
Do you presently have pain	___	___	Tuberculosis	___	___
Are you under physician's care now	___	___	Radiation Treatment	___	___
Have you ever had:			Blood Thinners (i.e., Coumadin)	___	___
Abnormal heart condition	___	___	Hepatitis	___	___
Artificial valve	___	___	Blood transfusion (give date)	___	___
Rheumatic fever	___	___	Venereal disease	___	___
Used Fen Phen	___	___	AIDS or HIV positive	___	___
Diabetes			Biophosphonates (i.e., Fosamax)	___	___
Abnormal bleeding	___	___	Jaw joint pain, clicking, etc.	___	___
Artificial joint	___	___	Females, are you pregnant	___	___
Unusual reaction to any drug or Local Anesthetic	___	___	Females, are you taking oral contraceptives (antibiotics render oral contraceptives ineffective)	___	___
Smoking and/or Tobacco	___	___	Is there any other information about your health we should know	___	___
Asthma	___	___			
Allergies (specify)	___	___			

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical conditions or medications can affect dental treatment, I understand the importance of and agree to notify the dentists of any changes are any subsequent appointment.

Signature: Date:

INFORMED CONSENT

I authorize Dr. Holt and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful, both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

AUTHORIZATION AND RELEASE

I authorize the dentist to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby do abide by the conditions outlined here in.

Signature: Date:

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