Chris Cornman DDS
FAMILY DENTISTRY
5790 Williams Dr Georgetown, TX 78633
(512) 869-8867

WELCOME

one — ABOUT YOU

Today's Date:_________/________/_________

Patient Name: ______________________________________
LAST FIRST MI

What you prefer to be called:__________________ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age:_____ SS#: _______________

Driver's License_____________________________________

Mailing Address: _____________________________________

____
CITY STATE ZIP

Home Phone: (_________) ___________________________

Work Phone: (_________) ___________________________

Cell Phone: (_________) ___________________________

E-Mail Address: ______________________________________

Referred By: ____

Employer:___________________________How Long?________

Occupation: ____

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Spouse's Name: _______________________________________

Do you have children? ❑Yes ❑No How many?____________

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: _______________________________________

____
CITY STATE ZIP

SS#:____

Payment method: ❑Cash ❑Check ❑Credit Card (V/MC/Disc)

______________________________ _______ ___________
❑Credit Card – Enter card # above (if accepted) Exp. Security Code

____
Signature

two — INSURANCE INFO

Primary Dental Insurance _________________________________

Address: ____

____
CITY STATE ZIP

Phone: (__________) _______________________________

Insured's ID/SSN#: ___________________________________

Group # (Plan, Local, or Policy #) ___________________________

Insured's Name: ______________________________________

Relation:____________________ Date of Birth: ____ / ___ / ____

Insured's Employer:____________________________________

Initials — I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four — IN EVENT OF EMERGENCY

Whom should we contact? _______________________________

Relation: ____

Home Phone: (_________) ___________________________

Work Phone: (_________) ___________________________

Cell Phone: (_________) ___________________________

PLEASE CONTINUE ON BACK

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How long? ______________________________

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ______________________________ (______) ______________
NAME PHONE #

Last Dental Exam: _____ / _____ / _____ Last Dental X-rays: _____ / _____ / _____

Times a day you brush? ________________ Times a week you floss? ________________

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications are you taking?

Please list: ____

____

____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis / Rheumatism
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Asthma
Y N Back Problems
Y N Bleeding Problems
Y N Cancer / Tumors
Y N Chemotherapy
Y N Chest Pains
Y N Congenital Heart Defect
Y N Cosmetic Surgery
Y N Diabetes / Hypoglycemia
Y N Difficulty Breathing
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Frequent Neck Pain
Y N Glaucoma
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surg / Pacemaker
Y N Hepatitis A, B or C
Y N High Blood Pressure
Y N HIV + AIDS/ARC
Y N Jaw Problems TMJ/TMD
Y N Kidney Problems
Y N Leukemia
Y N Liver Problems
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Nervousness
Y N Psychiatric Problems
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Stomach Problems / Ulcers
Y N Stroke
Y N Thyroid Problems
Y N Tobacco Use
Y N Tuberculosis TB
Y N Venereal Disease

Please list any other surgeries or medical conditions you have or ever had:

____

____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics

❑ Codeine ❑ Erythromycin ❑ Others: ______________________________

For women: Are you taking Birth Control pills? ❑ Yes ❑ No

Are you pregnant? ❑ No ❑ Yes / How long? __________ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full or all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date _____ / _____ / _____

❑ Adult patient ❑ Parent or Guardian ❑ Spouse