Welcome to the office of Dr. Renee Corbitt

Purpose of this visit____ Date________________
Name____ Sex: F ______ M _______
Address_______________________________________City________________Zip___________
Home email ____
Home Phone (_____) _________________Cell Phone (_____) _____________________
Work Phone (_____) _________________ Pager (_____) _______________________
Date of Birth______________ Age_____ Marital Status ________ Height_______ Weight_______
SS# _______________________ Driver's License #______________________ State __________
Your Employer____________________________________ Occupation______________________
Address _____________________________________ City________________ Zip ___________
Work Email ____

Spouse or Responsible Party's Name_____________________________ Relationship __________
Employer ____________________________________ Occupation_________________________
Address ____________________________ City ________________ Zip _________________
Home Phone # _____________________________ Work Phone # _______________________

Emergency Contact Name____________________________________Relationship_____________
Address ____________________________ City ________________ Zip _________________
Home Phone # _____________________________ Work Phone # _______________________

Former dentist____
How were you referred to the office? ____

Insurance Information

Are you covered by dental insurance? Yes ________ No ________

You are responsible for *all* charges incurred regardless of any insurance coverage or payment. We are not contracted with your insurance carrier. If we file your insurance, you are required to pay your estimated portion at the time services are rendered. We must have verified your insurance coverage in order to file your insurance. Initials_________

Primary Insurance:
Name of Insured_______________________
Insured's employer_____________________
Insured's SS#__________________________
Date of birth__________________________
Relationship to insured_________________
Name of Insurance Co. __________________
Group/Plan #__________________________

Secondary Insurance:
Name of Insured_______________________
Insured's employer_____________________
Insured's SS#__________________________
Date of birth__________________________
Relationship to insured_________________
Name of Insurance Co. __________________
Group/Plan #__________________________

Dental Information

How would you describe your current dental health? ____
Date of your last dental visit and what was done: ____
Have you had any difficulty with dental treatment in the past? Yes __________ No _____________
Please explain.____
____
Have you ever had an injury to your face or jaws? ____
Do you have any popping, clicking or pain of your tempromandibular joint? Yes______ No______
If yes, please explain.____
Do you have frequent headaches or migraines? Yes______ No_________

Would you like nitrous oxide (laughing gas) with treatment? Yes _________ No ________
Would you like sedation for your dental treatment? Yes _________ No _________

Is there anything about your teeth or smile that you would like to change? Yes _____ No ____
If yes, please explain.____
____
____

Do you have or have had a history of any of the below. Please check all that apply.
_______ bleeding gums when you brush
_______ had orthodontic treatment (braces)
_______ loose teeth
_______ dry mouth
_______ bad breath
_______ mouth breathing
_______ grind or clinch your teeth
_______ wear removable appliances (retainer, partial(s) or denture(s))
_______ periodontal treatment (deep cleaning or gum surgery)
_______ biting hard objects (pens, etc.)
_______ nail biting
_______ food collection areas
_______ difficulty with swallowing
_______ cold sores (fever blisters)
_______ apthous ulcers
_______ oral piercing(s)

Is there any sensitivity in your mouth to any of the below. Please check all that apply.
cold _______ heat_______ sweets _______ chewing or biting pressure _________

Are you allergic to or have had a reaction to:
latex______ local anesthetics (Novocain-like drugs) _______ to metals?________

Medical Information and History

Are you in good health? Yes ________ No _________ Don't know ____________
Has there been any change in your general health in the last year? Yes _____ No _____
Have you had any serious illness, surgery or been hospitalized in the last 5 years? Yes____ No ____
If yes, describe and give approximate dates ____
____
____
Are you currently under the care of a physician (MD or DO) for a specific condition(s)?
Yes____ No ____ If yes, please explain. ____
____
____
Date of last physical ____________________

Name of physician___________________________________ Phone # ________________________
Name of physician___________________________________ Phone # ________________________

Please list all medications you are allergic to: ____
____
____

Please list all of the prescription medication, over the counter medication, vitamin supplements, herbal supplements and/or diet supplements that you take. Please list the name, the strength and how often you take the medication(s).

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

For women only:
Are you or could you be pregnant? Yes ____ No _____
Are you trying to become pregnant at this time? Yes _____ No _____
If pregnant, your expected due date: ____________________
Name of OB/GYN ___________________________ Phone #________________________
Are you nursing? Yes _____ No ______
Are you taking birth control pills or using the birth control patch? Yes _____ No ______
Are you taking hormone replacement therapy? Yes ______ No ________
Have you had the Gardia vaccine (HPV) Yes______ No _________

Do you have a history of the following? Please check all that apply:

______Antibiotics prior to dental work
______Rheumatic fever
_____ Rheumatic heart disease
______Heart Murmur
______Mitral Valve Prolapse
______Artificial Heart Valve
______Pacemaker, when? __________
______Damaged heart valves
______Congenital heart defects
______Heart Surgery, when? _______________
______Heart Attack, when? ________________
______Angina
______Chest pain on exertion
______High blood pressure
______Low blood pressure
______Other heart problems _______________
______Joint replacement, which joint(s) and when____
______Have you ever had a blood transfusion? When? ____
______Organ transplant? When and explain: ____
______Diet pills Pondimin_____ Redux_____ Phen-fen______ Other_______

Y N Liver disease Hepatitis What type? A_____ B______ C______ Other specify__________
Y N Autoimmune Disease Lupus_______ Arthritis ______ Rheumatoid arthritis ________
Y N Human Immunovirus (HIV positive status)
Y N Acquired Immune Disease (AIDS)
Y N Sexually transmitted disease(s), specify: ____
Y N Cancer/tumors/chemotherapy/radiation treatment
Y N Lung disease, please specify: Asthma _______ Tuberculosis _____ emphysema_____
COPD ______ Bronchitis _____ chronic cough_____ other______

Y N Diabetes Type1-Insulin dependent ______ Type 2 ________ Diet __________
Y N Thyroid disease hypothyroidism (low) ______ hyperthyroidism (high) ______
Y N Kidney disease, please specify ____
Y N Gastrointestinal disease ulcer______ colitis_________ acid reflux (GURD) ______
Y N Eating disorder, please specify: ______________
Y N Seizures or convulsive disorders epilepsy________ other________
Y N Neurological disorders If yes, specify __________________________
Y N Stroke When?____
Y N Blood disorder, please specify:
Anemia ________ hemophilia _______ sickle cell anemia _______ other________
Y N Trouble with eyes cataracts_______ glaucoma _______ other ________
Y N Loss of hearing right ______ left_________ Cochlear Implants____________
Y N Tattoos How many ___________ Age of oldest tattoo _________________
Y N Mental health disorders if yes, specify____________________________
Y N Consider yourself a nervous person?
Y N Have you ever taken medications for nervousness or depression?
Y N Do you drink alcoholic beverages?
If yes, how much alcohol did you drink in the last 24 hours? ______________
In the past week? ______________________________
Y N Have you ever used tobacco? If yes, please check all that apply.
cigarettes______ chewing tobacco ______ snuff (dip) ______ cigar______
pipe________
How long have you used tobacco?______________________________________
How much do you use in a day? _______________________________________
How much do you use in a week? ______________________________________
Y N Are you alcohol and/or drug dependent? If yes, have you received treatment?
If yes, when and for what ____
Y N Do you or have you ever used drugs or other substances for recreational use?
If yes, please list: ____
____
Frequency of use (daily, weekly, etc.)_____________________________
Number of years of use. ____
Y N Do you have any disease, condition or concern not listed above? If yes, please specify.
____
____
____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

____ _____________
Signature of person completing the health history **Date**

If a person other than the patient completed this form, please identify. ______________________

_______________________________________ ______________________
Signature of person reviewing this form/date **Renee Corbitt, DDS/date**