Dr. Natalie A. Corley & Dr. Chad A. Corley
217-330-6217 www.corleyfamilydental.com

Thank you for choosing **Corley Family Dental** to care for your oral health. We want you to feel **relaxed**, **comfortable**, and **well informed** during your visit. Our goal is to educate you on your oral health and promote overall wellness through healthy eating habits and preventative oral hygiene. We understand visits can be overwhelming and encourage you to call with any questions you may have regarding treatment.
Sincerely, Dr. Natalie & Chad Corley & Team

Patient Information (CONFIDENTIAL)

Today's Date ___________________

Name ____ Preferred Name _______________________________
Birthdate ________________________ SSN ___________________________________ Gender : Male ___ Female ___
Address ____ City/State _______________________ Zip _________
Home ph# __________________________ Work ph# ___________________________ Cell Ph# _______________________
E-mail ____ Preferred contact method: ________________________
Check appropriate box ___Child ___Single ___Married ___Divorced ___ Widowed
If over 19, is patient Full Time College Student? ___Yes ___No
If yes, Name of School _____________________________________ City, State ______________________________
Patient or Parent/Guardian's Employer ______________________________
Business Address ____ Work Ph# _____________________________
City, State, Zip ____
Spouses or Parent/Guardian's Name _________________________________
Employer ____ Work Ph# _____________________________
City, State, Zip ____
Person to contact in case of an emergency? ____________________________PH# ______________________________
How did you hear about our practice? ____

Responsible Party

Name of person responsible for account (if different than self) ____
Address ___________________________________ City/State _______________________ Zip _______________
Phone# ____________________________________ SSN ___________________________Dob ________________
Employer __________________________________ Work Ph# ____
Marital Status__________________ Is this person currently a patient in our office ___Yes ___No

Dental Insurance Information

Member ID# ____
Insured Employee ___________________________ Birthdate ______________ SSN _________________________
Employer __________________________________ Phone ____
Insurance Company__________________________ Group# __________________ Phone ___________________
Address ___________________________________ City/State _______________________ Zip _______________

Insurance claims are submitted daily as a courtesy to our patients. We do ask that you pay your estimated co-payment & deductible at the time of service. Thank you for your cooperation.

Signature __________________________ Date ____________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___Yes ___No IF YES, COMPLETE BELOW
Insured Employee ___________________________ Birthdate ______________ SSN _________________________
Employer __________________________________ Phone ____
Insurance Company_____________________ Group# ______________ Member ID#__________________
Address ___________________________________ City/State _______________________ Zip _______________

Thank you!