CORLEY FAMILY DENTAL

MODERN • COMPASSIONATE • EXCELLENCE

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: _____

Circle appropriate box: Single Married Divorced Widowed

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? _____

Dental Insurance Information

Insured Employee _____ Member ID# _____
Employer _____ Birthdate _____ SSN _____
Insurance Company_____ Phone _____
Address _____ Group# _____ Phone _____
City/State _____ Zip _____

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 _____

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 _____

Patient Name _____

Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now? If yes, please explain _____ _____	☐	☐
2. Have you ever been hospitalized for any surgical or serious illness within the last 5 years? If yes, please explain _____ _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? Please list: _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you allergic to anything? If so, what: _____ _____	☐	☐
7. Have you ever had any problems with dental anesthetic?	☐	☐
8. Are you under treatment for **Osteoporosis?** Please list medications: _____	☐	☐
9. Have you ever taken bisphosphonate medications such as: Fosamax, Boniva, Actonel, Reclast?	☐	☐
Are you currently pregnant?	☐	☐

10. CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR NOW HAVE:

High/Low blood pressure	Heart Attack
*Rheumatic Fever	Asthma
AIDS	Thyroid problems
Heart Disease	Pacemaker
*Heart murmur	Anemia
Emphysema	Cancer
Arthritis	Liver disease
Heart trouble	*Mitral Valve Prolapse
Diabetes	Hepatitis
Artificial Heart Valve	Oral Herpes/Cold Sores
Shortness of breath	TMJ
Venereal Disease	Stroke
Sleep Apnea	
*Hip, Knee or Joint replacement/implants	
Pain in chest, neck, arm or jaw on exertion	
Other _____	

11. **Do you need to Pre-Med with antibiotics for any of the above * conditions?** _____

Dental History

Date of Last Exam _____ Date of Last Full Series of X-Rays _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot/cold?	☐	☐
3. Do you feel pain in any of your teeth?	☐	☐
4. Do you have any sores or bumps in your mouth?	☐	☐
5. Do you have areas of concern today?	☐	☐
6. Are you interested in whitening your teeth?	☐	☐

7. CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOU:

Clicking of jaw joints	Loose teeth
Pain (jaw, ears or side of face)	Dizziness
Difficulty in opening or closing	Difficulty in swallowing
Frequent headaches	Snoring
Clenching or grinding of teeth	Excessive tiredness

Signature _____ Date _____

WELCOME TO CORLEY FAMILY DENTAL

Please read and sign below

Insurance policy- We accept most major insurance plans and will work with you to help you understand your benefits. As a courtesy, we verify your insurance coverage and can provide an ESTIMATE of your out-of-pocket expenses for you. If your insurance takes over 60 days to pay their portion, you as the patient will be financially responsible for the remaining balance.

Co-pay's deductibles and no covered services- ALL ESTIMATED co-pays, deductibles, and non-covered services are due AT TIME OF SERVICE. We accept all forms of payment, including cash, check, card, and CareCredit.

Treatment plans- if our doctors recommend further care, our treatment plan coordinator will review and explain all fees, estimated insurance (if applicable), and your portion due at the next time of service. You will also receive a signed copy of this plan.

Missed appointments- we request the courtesy of a 24hr notice when cancelling or rescheduling an appointment. This allows us to get our other patients in who need care. A fee of $50 will be add to your account in the event of a no show, or short notice cancellation.

Balances returned checks and collection policy- you will be expected to pay any outstanding balances when scheduling an appointment. There will be a $50 charge added to your account if a check is returned by your bank. After we have attempted to contact you If the account is not paid within 90 days of the date of service and no financial arrangements have been made, it may be turned over to a collection agency. If your account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.

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.

Signature: _____

Date: _____

ACKOWLEDGEMENT of RECEIVING
NOTICE of PRIVACY PRACTICES

Corley Family Dental
160 W McKinley Ave.
Decatur, IL 62526

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

I give permission to: Corley Family Dental to share my health information with:

_____

so that this person or entity may assist me with my health care issues.

Corley Family Dental may share my health information until I revoke the authorization.

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature acknowledging receipt of our Notice of Privacy Practices, but was unable to do, also as documented below:

Date:	Initials:	Reason: