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**, Drs. Natalie Corley & Chad Corley & Team

Your Child

Child's Name ______________________________
Nickname ____________________ Gender M / F
Birthdate ______________________ Age ________
SSN ______________________________
Child's Home Address ______________________________
City/State ____________________Zip ____________
Phone ______________________________

Responsible Party

Name ______________________________
Relationship ______________________________
Address ______________________________
City/State ____________________Zip ____________
Phone ______________________________
E-mail ______________________________
SSN ______________________________

Mother ___Stepmother ___ Guardian

Name ______________________________
Home Phone _________________ Cell# ______________
Date of Birth______________________________
Employer ______________________________
SSN ______________________________
Marital Status ___Single ___Married ___Divorced
___Widowed ___Separated

Father ___Stepfather ___ Guardian

Name ______________________________
Home Phone _________________ Cell# ______________
Date of Birth______________________________
Employer ______________________________
SSN ______________________________
Marital Status ___Single ___Married ___Divorced
___Widowed ___Separated

Primary Insurance

Insured's Name ______________________________
Relationship ______________________________
Birthdate _______________ SSN ________________
Employer ______________________________
Insurance Co.______________________________
Member ID#______________________________
Group # ______________________________
Ins. Co. Address ______________________________
City/State ______________________ Zip __________
Phone ______________________________

Additional Insurance

Insured's Name ______________________________
Relationship ______________________________
Birthdate _______________ SSN ________________
Employer ______________________________
Insurance Co.______________________________
Member ID#______________________________
Group # ______________________________
Ins. Co. Address ______________________________
City/State ______________________ Zip __________
Phone ______________________________

Responsible Party's 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: