CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Tooth sensitivity to HOT/COLD/SWEET	Pain when chewing
Pain in jaw/joint	Grinding or Clenching

REVOLUTIONARY TREATMENT ALTERNATIVES CAN CHANGE YOUR SMILE **QUICKLY** and **EASILY**! IF YOU COULD CHANGE YOUR SMILE, YOU WOULD (**circle all that apply**):

Make them brighter	Make them straighter
Close spaces	Replace black, metal fillings with natural tooth-colored fillings
Repair chipped teeth	Replace missing teeth
Replace old crowns that do not match	Have a smile makeover

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 to 10 (10 being the highest):.

1. How important to you is your dental health?:	1	2	3	4	5	6	7	8	9	10
2. Where would you rate your dental health?:	1	2	3	4	5	6	7	8	9	10

Why did you leave your previous dentist?: ____

What is the most important thing to you about your future smile and dental health?:

____

____

What is the most important thing to you about your dental visit today?:

____

____

A)I have read and agreed to the financial procedures of this office. I understand that charges are expected to be paid on the date of service. B)If my account is secured with a credit card, I authorize any past due amounts to be charged to my securing credit card. C)I grant my permission to the office and it's assignee's to contact me at my place of employment to discuss matters related to this form. D) I authorize my insurance company to pay Dr. Cornette, and all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. E) I authorize Dr. Cornette and staff to release all information necessary to secure the payment of benefits or to facilitate my care with another dental office/facility. F) I acknowledge that I am aware of the cancellation police: any cancellation without 48 hr. notice results in a $50 fee. E) I acknowledge RECEIPT OF NOTICE OF PRIVACY PRACTICES.

Signature:____ **Date:**________________________

TODAY'S DATE: ______________ PT. NAME _________________________

1. Have you ever had a blood transfusion	____YES	____NO
If YES, when? __________________		
2. List any history of any illnesses and/or surgeries (General and Cosmetic) . . . . . . **PLEASE SPECIFY**: ____	____YES	____NO
3. Have you ever taken any dietary drugs (e.g., Fen-Phen or Redux)	____YES	____NO
If YES, when? _______ what? ___________		
4. Are you pregnant or nursing.	____YES **Due Date:** __________	____NO
5. Are you taking birth control pills	____YES	____NO
6. **Are you taking any other medications . . . .**	____YES	____NO
If YES, please list all medications below:		
7. Are you ALLERGIC to Penicillin or any related drug	**____YES**	**____NO**
If YES, please list all medications below:		
8. Are you **ALLERGIC** to **LATEX** or any other drug.	**____YES**	**____NO**
9. List the name and number of person to contact in case of an emergency (not in the same household):		

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Abnormal Bleeding/surgery	Chemical Dependency	Heart Attack	Rheumatic Fever
AIDS/HIV infected	Chemotherapy	Heart Murmur	Scarlet Fever
Anemia	Congenital/Rheumatic heart disease	Hemophilic	Sickle Cell
Artificial Joints	Cortisone Treatment	Hepatitis A,B,C,D	Stroke
Asthma	Damaged Valve	Kidney Trouble	Stroke
Blood Disease	Diabetes	Liver Disease	Syphilis
Blood Pressure Problems	Emphysema	Mitral Valve Prolapse	Thyroid Problems
Blood Transfusion	Epilepsy/seizures	Pacemaker	Tobacco Habit
Breast Implants	Fainting spells	Radiation Treatment	Tuberculosis
Cancer	Glaucoma	Respiratory Disease	Tumors/Malignancy
Other:__________			Venereal Disease

I have provided correct medical information, consented to any necessary medications, or anesthetics to be administered by Dr. Cornette or his staff, any dental procedures for diagnostic or dental treatment. I will not hold Dr. Cornette or his staff responsible for any errors or omissions that I have made in the completion of this form. Patient Signature:________________________

IF SIGNING FOR A MINOR, YOU ARE INDICATING THAT YOU HAVE THE LEGAL AUTHORITY TO SEEK CARE FOR THEM.

Please be sure to fill out the other side.