PREFERRED DENTIST:
❑ HUTSON E. MCCORKLE, D.D.S., P.A.
❑ MICHAEL G. MCCORKLE, D.M.D.
❑ SCOTT T. SIMPSON, D.M.D.

DELANEY PARK DENTISTRY

INITIALLY REVIEWED BY: _____ INITIALS
DATE: _____

CONFIDENTIAL MEDICAL HISTORY

Patient Name _____ Preferred Name _____ Date of Birth _____
Home Phone _____ Work Phone _____ Cell Phone _____
Home Address _____
Street *City* *Zip*
Social Security # _____ Patient's Employer _____
Business Address _____
Name of Spouse _____ Person Responsible for Account _____
Emergency Contact: Name _____ Phone _____
Referred By _____
E-Mail Address: _____ May we contact you by E-Mail? Y❑ N❑

INSURANCE INFORMATION

Dental Insurance Company _____ Group # _____
Insurance Company Address _____ Phone # _____
Insurance Policy Holder _____ Employed By _____
Policy Holder Date of Birth _____ Social Security # _____
Member Phone # _____ Member ID # _____

MEDICAL HISTORY

Are you currently under the care of a physician? ..... Y❑ N❑
If yes, what condition(s) are you being treated for? _____
Have you ever been hospitalized or had a major operation? ..... Y❑ N❑
Please list any medications (prescription or over-the-counter) you are currently taking _____
_____
Do you use tobacco products? Y❑ N❑ If yes, how many packs/day or cans/day? _____
Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other _____
If yes, please describe reaction _____
Do you currently have, or have you had in the past, any of the following conditions? (Check appropriate boxes below)

AIDS/HIV Positive	Y❑ N❑	Diabetes	Y❑ N❑	High Blood Pressure	Y❑ N❑
Alzheimer's Disease	Y❑ N❑	Drug Addiction	Y❑ N❑	Osteoporosis	Y❑ N❑
Anemia	Y❑ N❑	Easily Winded	Y❑ N❑	Irregular Heartbeat	Y❑ N❑
Arthritis/Gout	Y❑ N❑	Emphysema	Y❑ N❑	Kidney Problems	Y❑ N❑
Artificial Heart Valve	Y❑ N❑	Excessive Bleeding	Y❑ N❑	Liver Disease	Y❑ N❑
Artificial Joint	Y❑ N❑	Excessive Thirst	Y❑ N❑	Pain in Jaw Joints	Y❑ N❑
Asthma	Y❑ N❑	Fainting Spells/Dizziness	Y❑ N❑	Thyroid/Parathyroid Disease	Y❑ N❑
Breathing Problem	Y❑ N❑	Frequent Cough	Y❑ N❑	Psychiatric Care	Y❑ N❑
Bruise Easily	Y❑ N❑	Frequent Headaches	Y❑ N❑	Shingles	Y❑ N❑
Cancer or Tumors	Y❑ N❑	Glaucoma	Y❑ N❑	Stomach/Intestinal Disease	Y❑ N❑
Chest Pains	Y❑ N❑	Hay Fever/Sinus Trouble	Y❑ N❑	Stroke	Y❑ N❑
Cold Sores/Fever Blisters/Ulcers	Y❑ N❑	Heart Trouble/Disease	Y❑ N❑	Tuberculosis	Y❑ N❑
Convulsions/Epilepsy	Y❑ N❑	Hepatitis A, B, or C	Y❑ N❑	Venereal Disease	Y❑ N❑

Do you have, or have you had in the past, any medical conditions not listed above? ..... Y❑ N❑
If yes, please list _____
Women only: Are you…
Pregnant or planning pregnancy? Y❑ N❑ Taking oral contraceptives? Y❑ N❑ Nursing? Y❑ N❑
Chief Dental Complaint: _____
Date of Last Dental Visit: _____ Date of Last Dental Cleaning: _____
Additional Comments: _____
_____

CONSENT FOR TREATMENT

I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetics or premedications that may be advised by the doctor. I understand that I will be responsible for any financial obligation for treatment on myself or the above named person. To the best of my knowledge, the questions on this form have been answered accurately. I understand that it is my responsibility to inform the dental office of any changes in my (or patient's) medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

Hutson E. McCorkle, D.D.S., P.A.
Michael G. McCorkle, D.M.D.
Scott T. Simpson, D.M.D.

605 Delaney Avenue
Orlando, Florida 32801
Telephone 407.422.3131

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the 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 to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

(For Office Use Only)

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____

_____