

**PERSONAL INFORMATION**

Mr./Mrs./Ms/Miss/Dr. \_\_\_\_\_  
*Last* \_\_\_\_\_ *First* \_\_\_\_\_ *Middle Initial* \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_\_  
 Address \_\_\_\_\_ apt. \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Home Ph# \_\_\_\_\_  
 Work Ph# \_\_\_\_\_ Cell # \_\_\_\_\_  
 \*\*E-mail\*\* \_\_\_\_\_  
**HOW DID YOU FIND OUT ABOUT THE OFFICE?** \_\_\_\_\_

**MEDICAL HISTORY**

**YOUR PHYSICIAN NAME, ADDRESS AND PHONE #** \_\_\_\_\_  
 \_\_\_\_\_

**Do you have or ever had any of the following? Please, check either Yes or No as applicable:**

	YES	NO		YES	NO		YES	NO
Bleeding problems			Diabetes			Tuberculosis		
Hepatitis			Rheumatic Fever			Anxiety/Nervous		
Hypertension			Heart Murmur			HIV/ AIDS		
Artificial Joints			Fainting Spells			Kidney Problems		
Lung Problems			Asthma			Radiation Therapy		
Cancer			Epilepsy, Seizures			Migraines		

**ALLERGIES – HYPERSENSITIVITIES**

	YES	NO		YES	NO		YES	NO
Penicillin			Aspirin			Codeine		
Anesthetic			Latex			Other _____		

**Are there any other health related issues you would like to make us aware of?** \_\_\_\_\_  
 \_\_\_\_\_

**Have you been hospitalized in the last two years?** \_\_\_\_\_ **If yes, please explain** \_\_\_\_\_

I hereby authorize Dr. Ruslan Korobeinik to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Korobeinik to make a thorough diagnosis of my dental needs. I also authorize Dr. Korobeinik to prescribe any and all forms of medication that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I further authorize the use of my name or a photograph(s), video, slides or any other images as may be necessary of me, with or without my given name or with a fictitious name for advertising, education or any other lawful purpose and I release and forever discharge him from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided. I have received a copy of this office's Notice of Privacy Practices.

**SIGNATURE OF THE PATIENT** \_\_\_\_\_ **DATE** \_\_\_\_\_