139 N. Main St.
Cortland NY 13045

(607)753-0602

Stuart R. Douglas DMD, PLLC

Patient Information

Today's Date:_________

Chart #. [ ]
FOR OFFICE USE ONLY

Patient Name: [ ] Last [ ] First [ ] MI [ ] Preferred Name

Title: [ ] Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: [ ] SS #. [ ] Prev. Visit: [ ]

Email Address: [ ] Best time to call: [ ]

Phone: [ ] Home [ ] Work [ ] Ext [ ] Mobile [ ] Fax [ ] Other

Address: [ ] [ ]
[ ] City [ ] State [ ] Zip Code

Responsible Party

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: [ ] Last [ ] First [ ] MI [ ] Preferred Name

Employer Name:____

Insurance Company:_____________________________________ ID#___________

◯ Yes ◯ No

Secondary Insurance Company: ____________________________ ID# __________

◯ Yes ◯ No

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Dental History

Former Dentist________________________________ Date of Last Dental X-rays_________
Reason for today's visit____
How often do you brush?___________________How often do you floss?_____________

Medical History

Please list all medications you are currently taking: _________________________________
____
Allergies:____
(Women) Are you pregnant? _______ Nursing? _______

- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Artificial Joints Date:_______
- [ ] Anemia
- [ ] Asthma
- [ ] Bisphosphonates
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Chemical Dependancy
- [ ] Chemotherapy
- [ ] Circulatory Issues
- [ ] Cough, Persistant
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Headaches
- [ ] Heart Problems: Describe_____
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV +
- [ ] Jaundice
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous/ Anxiety Disorders
- [ ] Other__________________
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatice Fever
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

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Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Dr. Stuart R. Douglas and/or Dr. Marisa J Clifford may use my healthcare information and may disclose such information to any Insurance Comapny and their aganets for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. I understand that i am financially responsible for all charges whether or not payed by insurance. I authorize the use of my signature on all insurance submissions. I consent to all recommended treatment presented by above-named doctors.

Signature: ______________________________ Date: [ ]

Acknowledgement of Reciept of Notice of Privacy Practices

*** You may refuse to Sign this document****

I, ______________________________ have received and read a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign
_______ Communications barriers prohibited obtaining the acknowledgement
_______ An emergency situation prevented us from obtaining acknowledgement
_______ Other (please specify) ______________________________

Response Date: [ ]

STUART R. DOUGLAS, DMD, PLLC
MARISA J. CLIFFORD, DMD
139 NORTH MAIN STREET
CORTLAND, NEW YORK 13045

TO:

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS, X-RAYS, AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO THE ABOVE NAMED DOCTOR.

RE:____

THANK YOU,

PATIENT SIGNATURE

DATE OF BIRTH