CORNERSTONE
FAMILY DENTAL

Patient Information

Name _____ Preferred Name _____

Age ____ Date of Birth_____ Male or Female Single/Married/Widowed/Separated/Divorced

SSN _____ (for patients under 18, please list the SSN of the adult responsible for the account)

For patients under 18: Name of person responsible for account _____

Physical Address _____City _____ State _____ Zip _____

Mailing Address _____City _____ State _____ Zip _____

Home # _____ Cell #_____Work #_____ Email_____

Circle the best place to reach you: Home Cell Work Email May we send text messages to your cell? Yes No

Employer: _____ Occupation (if student, then school patient attends): _____

Spouse Name:_____ **Who may we thank for referring you?**_____

Payment Information

Please select how you will pay for your dental visits:

_____ Self Pay– Please read and sign self-pay financial information sheet available at the front desk

_____ Insurance– I have an insurance plan to help cover dental expenses. I understand that I will owe an out of pocket portion at any appointment where the insurance company does not specify 100% coverage or deductible required.

Please read and sign the dental benefits financial information sheet available at the front desk.

In Case of Emergency

Primary Emergency Contact Name: _____ __ Relationship to patient: _____

Phone Number: _____ Cell Number: _____

Secondary Emergency Contact Name: _____ Relationship to patient: _____

Phone Number:_____ Cell Number: _____

All Patients Read and Sign

I give permission for my dentist and clinical team to take the necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I understand by signing this document I assume responsibility for any financial obligation for services rendered. I understand that Cornerstone Family Dental files my dental claims as a courtesy to me and any benefits quoted are an estimation and not a guarantee of payment. I have read, understood, and agreed to the statements on this page and confirm the information I have listed as true.

_____ _____

Signature of Patient or Responsible Party Date

Medical Information

Medical Doctor:_____ Mont/Year of last visit:_____

Please check any current condition:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves *
- ❑ Asthma
- ❑ Back problems
- ❑ Diabetes
- ❑ Family history of diabetes
- ❑ Excessive bleeding with surgery
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chemical dependency
- ❑ Circulatory problems
- ❑ Congenital heart lesions
- ❑ Cortisone treatments
- ❑ Cough, persistent or bloody
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Hepatitis (Type ___)
- ❑ Herpes
- ❑ Jaundice
- ❑ Joint Replacement*
- ❑ Kidney Disease
- ❑ Low blood pressure
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Pacemaker
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of breath
- ❑ Sinus trouble
- ❑ Stroke
- ❑ Swelling of feet/ankles
- ❑ Swollen neck glands
- ❑ Smoking
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth of head/neck
- ❑ Ulcer
- ❑ Venereal disease
- ❑ Unexplained weight loss

***Condition may require an antibiotic prescription before dental appointments**

Women:

Are you pregnant? Yes No
Taking birth control Yes No
Are you Nursing? Yes No

Cardiologist: _____ Orthopedic Surgeon:_____

Please list any surgeries or other significant changes since your last visit: _____

_____

Medications

Are you taking a bone disease/osteoporosis prevention medication such as Fosamax, Actonel, Boniva ? Yes No

Please list your current medications: (can attach a separate sheet if list is extensive) _____

_____ _____

_____ _____ _____

Pharmacy: _____City: _____ Phone: _____

Allergies

Circle all allergies: Aspirin Barbiturates Codeine Iodine Latex Sulfa

Penicillin Local Anesthetic Other: _____

New Patients: Dental History

Reason for todays visit _____Date of last dental visit (month/year): _____

Former Dentist: _____City/State: _____Approximate date of last dental x rays: _____

How often do you floss? _____How often do you brush? _____Rate your smile of a scale of 1-10? : _____What would you change about your smile?_____

Please check if you have any of the following:

- ❑ Bad breath
- ❑ Clicking/popping jaw
- ❑ Jaw joint pain
- ❑ Broken fillings
- ❑ Pain around ear
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Cold
- ❑ Loose teeth
- ❑ Sores/Growths in mouth
- ❑ Bleeding gums
- ❑ Dry mouth
- ❑ Food collection between teeth
- ❑ Mouth breathing
- ❑ Sensitivity to biting
- ❑ Blisters on lips/mouth
- ❑ Clenching/grinding teeth
- ❑ Lip/cheek biting
- ❑ Orthodontic treatment
- ❑ Swollen Gums
- ❑ Chewing tobacco
- ❑ Smoking