



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

Please check any current condition:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> CPAP User | <input type="checkbox"/> Joint Replacement*
(Date: _____) | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke (Date: _____) |
| <input type="checkbox"/> Artificial heart valves * | <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumor or growth of head/neck |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes (Type: _____) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Excessive bleeding with surgery | <input type="checkbox"/> Heart Attack or Stent
(Date: _____) | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis (Type _____) | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus trouble | |
| <input type="checkbox"/> Chemical dependency | | | |

*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

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

Cardiologist: _____ Orthopedic Surgeon: _____

Please list any and all previous surgeries to date: _____

Medications

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

Are you taking any Blood Thinners?: 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 today's 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:

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