CORNERSTONE DENTAL PC

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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 Mobile Work Ext Fax Other

Address:* Address 1 Address 2

* City * State * Zip Code

Whom may we thank for referring you to our office?

Dental Insurance

Name of Insured: Last First MI

Insured's Birth Date: **ID #:** **Group #:**

Insured's Address: Address 1 Address 2

City State Zip Code

Insured's Employer Name:

Employer Address: Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address: Address 1 Address 2

City State Zip Code

Medical History

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Congential Heart
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] HIV
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Are you taking any BLOOD thinners * ◯ Yes ◯ No

Are there any other health conditions you would like to disclose?

Please list any medications you are currently taking, one medication per line:

EMERGENCY CONTACT: Name & Phone# *

Dental Health

What are your immediate dental concerns?

Approximate date of last visit & purpose of that appointment.

What type of toothbrush are you using? How often do you brush?

- [ ] Manuel
- [ ] Electric
- [ ] Sonicare
- [ ] 2x/day
- [ ] 1x/day
- [ ] Seldom

How often do you floss?

- [ ] Daily
- [ ] couple times a week
- [ ] whats floss?

Consent for Services and Financial Policy

☐ * I hereby authorize the doctor (s) and/ or staff of Cornerstone Dental to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Professional services are rendered on a cash or cash equivalent basis only and payment is due in full at the time services are rendered. Debit and most credit cards are accepted. With approved credit, patients may be eligible for third-party financing which entitles patients to a revolving charge account upon approval of the application. Special arrangements, including third-party financing, must be made prior to any appointment for services. We file most major insurance forms with the understanding that you, the Patient, assign your rights to insurance benefits to us in full but we require that patients pay their estimated amount towards the total cost at the start of treatment. Please remember that all professional services are rendered to the patient and not to the insurance company. The patient is ultimately responsible for the total charges regardless of insurance filing or insurance company involvement.

☐ * By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

Response Date: _____