

Registration & History

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

PATIENT INFORMATION

Date: _____

Social Security #: _____ Email Address: _____

Name: _____ Birth Date: _____ Home Phone: (____) _____

First MI Last City: _____ State: _____ Zip: _____
Cell Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Check Appropriate: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

If patient is a student, name of school/college: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency: _____ Phone: _____

Preferred method for appointment confirmation: home phone work phone cell phone

RESPONSIBLE PARTY (if patient is under 18)

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

Social Security #: _____ Birth Date: _____ Work Phone: _____

INSURANCE INFORMATION

Name of Insured: _____ I.D. #: _____ Birth Date: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer: _____

Do you have additional insurance? Yes No *If yes, complete the following:*

Name of Insured: _____ Insured's S.S. #: _____ Birth Date: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer: _____

PATIENT DENTAL HISTORY

Previous dentist & location: _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1) Are you happy with your smile | <input type="checkbox"/> | <input type="checkbox"/> | 9) Are you interested in Bleaching? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 10) Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are your teeth sensitive to hot or cold liquids / foods? | <input type="checkbox"/> | <input type="checkbox"/> | 11) Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are your teeth sensitive to sweet or sour liquid / food? | <input type="checkbox"/> | <input type="checkbox"/> | 12) Have you ever had difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Do you feel pain in any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 13) Have you had any Orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 14) Have you ever had prolonged bleeding following Extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 15) Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Have you ever experienced any of the following problems in your jaw? | | | 16) Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 17) Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (Joint, Ear, Side or Face)? | <input type="checkbox"/> | <input type="checkbox"/> | 18) Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d) Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | <i>if yes, date of placement</i> _____ | | |

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: _____ Date of Last Exam _____

- | | | | | | | | | | |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|--------------|
| 1) Are you under medical treatment now? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 9) Are you allergic to or have you had any reactions to the following? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | |
| 2) Have you been hospitalized for any surgical operation or serious illness within the last five years? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates |
| 3) Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives |
| 4) Do you use Tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa | <input type="checkbox"/> | <input type="checkbox"/> | Asprin |
| 5) Do you use Alcohol or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| 6) Are you wearing Contact Lenses? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | |
| 7) Do you have shortness of breath upon mild to moderate exertion? | <input type="checkbox"/> | <input type="checkbox"/> | 10) Women Only | | | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 8) Do you have excessive thirst? | <input type="checkbox"/> | <input type="checkbox"/> | a) Are you pregnant or think you may be? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| | | | c) Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

- 11) Do you have or have you ever had any of the following?
- | | | | | | | | | |
|-----------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (Infectious) | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B (Serum) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV infection | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement (Hip, Knee) | <input type="checkbox"/> | <input type="checkbox"/> | Chemo Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss or Gain | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> |
- 12) Do you have any other health problems not mentioned? Yes No If yes explain: _____

APPOINTMENTS: A MINIMUM CHARGE WILL BE MADE FOR FAILED OR CANCELLED APPOINTMENTS WITHOUT PRIOR NOTIFICATION OF 24 HOURS. THIS FEE COVERS ONLY A PORTION OF THE OVERHEAD SUCH AS SALARIES, UTILITIES, ETC., WHICH STILL HAS TO BE PAID WHETHER YOU ARE PRESENT OR NOT ONCE AN APPOINTMENT IS MADE, PLEASE REMEMBER THIS TIME HAS BEEN RESERVED FOR YOU.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT: The undersigned hereby authorizes Cornerstone Dental to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Cornerstone Dental to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1^{1/2}% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

By signing this document, I hereby agree to allow "Cornerstone Dental Group" to charge to my credit card (Any credit card which was used to pay for my treatment) any unpaid balance remaining on my account after 180 days from my last date of treatment charged to my account.

_____ Patient Signature	_____ Date
_____ Parent or Responsible Party	_____ Relationship to Patient

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that provided incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Medical History Reviewed _____