

## GETTING TO KNOW YOU AS OUR PATIENT

Patient Name:		Social Security Number: - -	Birthdate: / /
Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Driver's License and State	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		City, State, Zip	
Email address:		Home Phone:	Cell Phone:
Employer Name and Address:		City, State, Zip	
Responsible Party Name (if a minor):		Social Security Number: - -	Birthdate: / /
Email address:		Driver's License and State	Work Phone:
Relationship to patient:	Responsible party's employer		Occupation
Business Address		City, State, Zip	
Dental Insurance Company		Group:	Subscriber:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Home Phone:	Cell Phone:
Spouse's Name		Social Security Number: - -	Birthdate: / /
Spouse's Email address:		Driver's License and State	Spouse's Cell Phone:
Spouse's Employer	Spouse's Occupation		Spouse's Work Phone:
Spouse's Business Address		City, State, Zip	
<b>How did you hear about our office?</b>			
Where did you find the phone number to Cornerstone Dental?			
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Sign by Building <input type="checkbox"/> Online Search <input type="checkbox"/> Referred by a friend/relative <input type="checkbox"/> TV/Radio Ad <input type="checkbox"/> Magazine Ad <input type="checkbox"/> Website <input type="checkbox"/> Other _____			
If you were referred, whom may we thank for referring you? _____			

### CONSENT

I will answer all health questions to the best of my knowledge. \_\_\_\_\_ (initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above names patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetic and x-rays as may be deemed necessary and advisable by the doctor.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## TERMS AND CONDITIONS

This office depends upon reimbursement from you, the patient, for the costs incurred for your dental care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in reimbursement from insurance companies and will credit such reimbursement to my account. However, Cornerstone Dental Associates, PLLC cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I authorize the release of medical/dental information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I understand that any fee estimate for dental care can only be extended for a period of 90 days. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions (and conditions on reverse side) and agree to their content.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.**

Unpaid balances over 90 days may be placed with an outside collection service or attorney, at an additional cost to you. In the event that legal proceedings become necessary to resolve any unpaid balance, attorney fees and court cost involved with the collection of the outstanding balance will be the responsibility of the patient/guarantor. There will be a 23% APR service charge applied to any account with a balance over 90 days and a \$39.00 fee for all returned checks.

I understand I am responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection at a rate of 35% of the total bill in addition to the amount of the total bill if collection procedures be required.

Responsible Party / Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health?  Excellent  Good  Fair  Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulpha			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. sexually transmitted disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	56. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY UPDATE:**

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_ Comment \_\_\_\_\_ Signature \_\_\_\_\_

_____	_____	_____
_____	_____	_____
_____	_____	_____

# DENTAL HISTORY

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

## WHAT IS YOUR IMMEDIATE CONCERN?

In case of emergency, please contact \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

### PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you ever had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_
6. Have you had any teeth removed? \_\_\_\_\_

### SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

### BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
12. Do you / would you have any problems chewing gum? \_\_\_\_\_
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? \_\_\_\_\_
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
15. Are your teeth crowding or developing spaces? \_\_\_\_\_
16. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
18. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_
19. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_
20. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

### TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? \_\_\_\_\_
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_
25. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
27. Do you get food caught between any teeth? \_\_\_\_\_

### GUM AND BONE

28. Do your gums bleed when brushing or flossing? \_\_\_\_\_
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
30. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
31. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
32. Have you ever experienced gum recession? \_\_\_\_\_
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
34. Have you experienced a burning sensation in your mouth? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_