REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: (circle one) Single / Married / Divorced / Separated / Widow / Minor / Other

Preferred Name:	Email:	Birth date: ___/___/_____	Age:	Sex (check one) O M O F

SSN#:	Cell Phone (_____)_____ Work (_____)_____Ext_____ Home(_____)_____	Best way to contact you for appointment reminders (circle one): Email / Text

Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer's Phone: (_____)_____	Employer's Address:

Spouse's Name:	Spouse's birth date:	Spouse's SSN#:	Spouse's Phone Number: (_____)_____	Spouse's Employer:

Whom may we thank for referring you?

INSURANCE INFORMATION

Insurance Name:	ID#:	Group#:	Subscriber's Name:	Birth date:	Relationship to patient:

Is patient covered by additional Insurance? (If so, please provide same insurance information as asked above):

ASSIGMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Cornerstone Dental all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I give my permission to Cornerstone Dental and its affiliates to use and disclose my health care information to the Insurance Company(ies) I so designate and their agents for the purpose of determining insurance benefits, obtaining payment for services, or the benefits payable for related services.

_____ _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Print Name of Patient, Parent, Guardian, or Personal Representative** **Date**

IN CASE OF EMERGENCY (specify someone who does not live in your household)

Name:	Home Phone: (_____) _____	Work Phone: (_____) _____	Relationship:

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No			
			Lip or cheek biting	☐ Yes	☐ No	How often do you floss? _____		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

Are you happy with your smile?	Do you have any dental concerns you would like to discuss?

OVER

HEALTH HISTORY

Primary Care Physician's Name and Phone Number:

Date of last primary care visit::

Have you ever taken a bisphosphonate drug, such as Aredia, Fosamax, Zometa, Boniva, Actonel, or Reclast, for osteoporosis or cancet therapy?
Circle one: Yes / No

Have you ever been told you need to take pre-medication/ antibiotic before a dental prodecure?
Circle one: Yes / No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS, SUPPLEMENTS AND REMEDIES

Please list any medications, supplements or homeopathic remedies you are currently taking and the correlating diagnosis.

_____

_____

Preffered Pharmacy Name and location:

_____

Phone Number: _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

PHYSICIANS

Please list names, location and phone numbers of all your attending doctors.

1.Dr._____ Location_____ Phone Number_____

2.Dr._____ Location_____ Phone number_____

Please list any surgeries or medical conditions you have or have ever had.

_____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly mutual understanding beetween provider and patient.
- Our policies requires payment in full at the time services are rendered, unless other formal written arragments have been made with our office management. If the account is not paid within 90 days of the date of service and no financial arragments have been made, you will be responsible for all legal fees, collection agency fees,interest charges and any other expenses incurred for collection of the debt.
- I authorize the staff of Cornerstone Dental to perform any neccesary services needed during diagnosis and treatment.
- Filling of insurance claims is a courtesy we provide to our patients. I authorize Cornerstone Dental to release any information required to process my insurance claims.
- I understand the above information and state this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to this information provided.

_____ _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Print Name of Patient, Parent, Guardian, or Personal Representative** **Date**