

CORNERSTONE FAMILY DENTAL

Patient Information

Patient Name _____ Name you prefer to be called _____
Age _____ Date of birth _____ Circle: 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 best place to reach you: Home Cell Work Email May we ever send text messages to your cell? YES NO
Employer: _____ Occupation (if a student, then school patient attends): _____
Spouse's 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 the 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.
Please read and sign the dental benefits financial information sheet available at the front desk.

In Case of Emergency

Emergency contact name: _____ Relationship to patient: _____
Phone number: _____ Cell number: _____ Address: _____ City: _____

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 these records may be used for educational purposes. I have read, understood, and agreed to the statements on this page and confirm the information I listed is true.

Patient's Signature (Guardian if patient is a minor)

Date

Please fill out other side as well

Medical Information

Medical Doctor: _____

Month/Year of last visit: _____

Please check any current condition:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Joint replacement* | <input type="checkbox"/> Swelling of feet/ankles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Smoking |
| <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"/> Tonsillitis |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tumor or growth of head/neck |
| <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Excessive bleeding with surgery | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever | *Condition may require an antibiotic prescription before dental appointments |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis (Type ____) | <input type="checkbox"/> Shortness of breath | Women: |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinus trouble | Are you pregnant? Yes No |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | Taking birth control? Yes No |
| | | | Are you nursing? Yes No |

Please list any surgeries or other significant changes since your last visit: _____

Medications

Are you taking a bone disease/osteoporosis prevention medication such as Fosamax, Actonel, or Boniva? 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: _____ Approx date of last dental xrays: _____

How often do you floss? _____ How often do you brush? _____ On a scale of 1—10, rate your smile: _____

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/bleeding 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 |