

# Cornerstone Dental Health History

We are please you have selected us to provide dental care for you and your family

## *Patient Information*

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_@\_\_\_\_\_ Home # ( ) \_\_\_\_\_

Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Sex  Male  Female  Single  Married  Other Student  FT  PT

Who may we thank for referring you to our practice? (Please Circle)

Phone book Newspaper Television Commercial Staff Member Insurance Website

Friend \_\_\_\_\_ Patient \_\_\_\_\_  
(name) (name)

## *Primary Insurance Information*

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Insured's D.O.B. \_\_\_\_\_

Employer \_\_\_\_\_ Primary Dental Insurance \_\_\_\_\_ ID# \_\_\_\_\_

## *Secondary Insurance Information*

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Insured's D.O.B. \_\_\_\_\_

Employer \_\_\_\_\_ Secondary Dental Insurance \_\_\_\_\_ ID# \_\_\_\_\_

## **Please give us your insurance card to copy**

### **CONSENT:**

The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.

I understand that where appropriate, credit bureau reports may be obtained.

I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

I authorize the use of my social security number to file my dental claim.

**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.**

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Reviewed by Dr. Littner \_\_\_\_\_ Date \_\_\_\_\_

# Cornerstone Dental Medical History

Do your gums bleed when you brush? Yes No  
 Are your teeth sensitive to hot or cold? Yes No    Pressure Yes No    Sweets Yes No  
 Do you grind or clench your teeth? Yes No  
 Do you have any fear of dental work? Yes No  
 Date of your last dental visit? \_\_\_\_\_ What was done at that time? \_\_\_\_\_  
 Former Dentist Name \_\_\_\_\_  
 What brought you to our office today? \_\_\_\_\_  
 How do you feel about the appearance of your teeth? \_\_\_\_\_  
 Is an antibiotic required prior to any dental work? Yes No

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Indicate which of the following you have had or have at the present. Circle each item that applies.

Angina	Cancer	Asthma
Chest Pain/Shortness of Breath	Chemotherapy	Diabetes
Congenital Heart Disease	Radiation Treatment	Thyroid Problems
Heart Murmur	Kidney Disease	Hypoglycemia
Heart Pacemaker	Hepatitis	Eating Disorders
Mitral Valve Prolapse	HIV Positive	Emphysema
Artificial Heart Valve	AIDS	Arthritis
Stroke	Glaucoma	Epilepsy/Seizures
Heart Surgery	Osteoporosis	Fainting/Dizzy Spells
Heart Attack	Sinus Trouble	Acid Reflux
High Blood Pressure	Artificial Joint	Lyme
Scarlet Fever	Anemia	Depression/Anxiety

**For Woman Only:**

Are you pregnant?  Yes  No    What Month? \_\_\_\_\_    Are you nursing?  Yes  No  
 Are you taking birth control pills? Yes No

Have you been hospitalized in the last 2 years? Yes No  
 Are you now taking any medications? Yes No  
 If yes, please list all current medications (including vitamins & homeopathic remedies):

**Allergies:**

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline
- Other

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there any disease, condition, or problem that you think this office should know about that we have not asked?

\_\_\_\_\_  
 \_\_\_\_\_  
 Office Use Only \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_