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CORNERSTONE
PERIODONTICS & IMPLANT DENTISTRY

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Patient Registration

Welcome to Cornerstone Periodontics!
We need certain information about you to make treatment as safe and successful as possible.
Please read and fill out carefully. If you have questions, be sure they are answered before signing this form.

Name: _____ _____ ____ _____ **Title:** _____
Last First Mi Preferred Name Mr./Ms./Mrs./etc.

Gender: ○Male ○Female **Family Status**: (Circle One) Married Single Child Other **SS #:** _____-_____-_____ **DOB:** _____

Phone: (____) _____ (____)_____ (____)_____ (____)_____
Home Cell Work Other

Address: _____ _____
Address 1 Address 2

City _____ State _____ Zip Code _____

Email Address: _____ **Best time to call:** _____

If minor, Guardian's name: _____ DOB: _____ Relationship: _____

The following is for: ○The patient ○The person responsible for payment ○Both ○Not applicable

Employer Name: _____ Employer Address: _____

In an emergency who should be notified? Please list Name and Phone number below: _____

Whom may we thank for referring you? _____

Dental Insurance: Yes___ No___ (Circle One) Aetna Ameritas BCBS Delta Dental Guardian Humana MetLife Other_____

Primary Dental Insurance:
Name of Insured: _____ _____ _____
Last First Mi
Insured's Birth Date: _____ ID# _____ Group #: _____ SS #: _____
Insured's Address: _____ City: _____ State: _____ Zip Code: _____
Insured's Employer Name: _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Patient's relationship to Insured: ○Self ○ Spouse ○ Child ○ Other
Insurance Plan Name: _____
Insurance Address: _____ City: _____ State: _____Zip Code: _____

Secondary Dental Insurance:
Name of Insured: _____ _____ _____
Last First Mi
Insured's Birth Date: _____ ID# _____ Group #: _____ SS # _____
Insured's Address: _____ City: _____ State: _____ Zip Code: _____
Insured's Employer Name: _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Patient's relationship to Insured: ○Self ○ Spouse ○ Child ○ Other
Insurance Plan Name: _____
Insurance Address: _____ City: _____ State: _____Zip Code: _____

Office Use Only: BP: _____ P: _____

Medical History: please make a check mark whether you now have or have ever been treated for:

□ Pre-Med – Amoxicillin	□ Pre-Med - Clindamycin	□ Pre-Med - Other	□ Allergies
□ AIDS/HIV Positive	□ Arthritis/Gout	□ Frequent Headaches	□ Irregular Heartbeat
□ Bisphosphonates	□ Asthma	□ Cancer	□ Artificial Joints
□ Anemia	□ Blood Disease	□ Dizziness	□ Diabetes Last A1C: Date:
□ Alzheimer's Disease	□ Glaucoma	□ Fainting	□ Heart Murmur
□ Epilepsy/Seizures	□ Artificial Heart Valve	□ Heart Disease	□ Hepatitis
□ Genital Herpes	□ Kidney Disease	□ Heart Problems	□ Hay Fever
□ High Blood Pressure	□ Low Blood Pressure	□ Excessive Bleeding	□ Mental Disorder
□ Pregnancy	□ Thyroid	□ Liver Disease	□ Pacemaker
□ Stroke	□ Recent Weight Loss	□ Stomach Problems	□ Ulcers
□ Hives/Rash	□ Renal Dialysis	□ Lung Disease	□ TMJ
□ Venereal Disease	□ Drug Addiction	□ Other	

General health (make a check mark): Excellent_____ Good_____ Fair_____ Poor_____

Name of Physician: _____ Date of last physical examination: _____

Any major change in health during the past year? □Yes □ No

Do you have any other medical problem(s) not listed above? □ Yes □ No If yes, please list: _____

Circle if you are allergic to: □Aspirin □Penicillin □ Codeine □ Latex □ Local anesthetic □ Other _____

Allergies to any other medications, not listed above? _____

Please list below any medications you are presently taking: (Name, for what condition?)

_____ _____ _____

_____ _____ _____

Explain in your words the reason of today's visit _____

Is your visit due to an accident? ___ Yes ___ No If yes, please explain and date of accident _____

AN X-RAY(S) MAYBE NECESSARY TODAY, TO ESTABLISH A COMPLETE DIAGNOSIS.

□Yes □No Do you consider yourself in good dental health?
□Yes □No Does food tend to become caught between your teeth?
□Yes □No Do you think that your teeth are affecting your health in any way?
□Yes □No Are you dissatisfied with the appearance of your teeth?
□Yes □No Are you dissatisfied with your chewing ability?
□Yes □No Have you noticed loosening of your teeth?
□Yes □No Do your gums often bleed when you brush your teeth?
□Yes □No Do you have any unpleasant odor or taste in your mouth?
□Yes □No Do you suffer from pain/swelling of your gums?
□Yes □No Are you missing any teeth? Reasons: ( ) Decay ( ) Gum Disease ( ) Other: _____
□Yes □No Have missing teeth been replaced?
□Yes □No Do you have any pain, clicking/popping around the front of your ears?
□Yes □No Do you clinch or grind your teeth while awake or sleep?
□Yes □No Do you bite your lips or cheeks regularly?
□Yes □No Do you hold objects with your teeth?
□Yes □No Do you breathe primarily through your mouth?

When did you have your last cleaning appointment? _____

How often do you see your dentist? □ 3 mo. □4 mo. □ 6mo. □ 12mo. □ Not Routinely
How often do you brush your teeth? □ Once a day □ Twice a day □ Every other day □ Not Routinely
How often do you floss? _____
Is your toothbrush ( ) Soft ( ) Medium ( ) Hard? Do you use a ( ) regular toothbrush or an ( ) electronic toothbrush?
What else do you use to clean your teeth? ( ) toothpick ( ) floss ( ) waterpic, ( ) other _____

Consent Form:

I have reviewed the health history and believe it to be correct. If there is a change in health or in medications taken, I will inform the doctor at my next appointment. I consent to treatment by the health care providers of this dental practice.

Patient's signature (Parent's if minor) _____ Date_____

Doctor's signature_____ Date_____

Assistant's initials_____

CONSENT TO RECEIVING PRIVACY NOTICE
ASSIGNMENT OF INSURANCE BENEFITS
CONSENT FOR EVALUATION

I was given the opportunity to read the Privacy Notice and object to disclosures of my protected health information.

I authorize that I am financially responsible for all charges whether paid by insurance or not.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I permit a copy of this authorization to be used in place of the original.

Patient signature _____ Date _____
(*If under 18 parent/guardian signature)*

Woman Only

Are you presently pregnant? ف Yes ف No Are you presently taking oral contraceptives? ف Yes ف No If so, read and sign the following:

Information and consent form patients taking oral contraceptives
It has been explained to me, and I understand, that oral antibiotics (and certain other medications) may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after my course of antibiotics or other medication is completed.

PATIENT'S SIGNATURE _____ DATE_____