Art A. Salinas, D.D.S.
Stacy R. Beltran, D.D.S., M.S.

CORNERSTONE
PERIODONTICS & IMPLANT DENTISTRY

Cornerstone Office
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Harrison, TX 78550
Phone: (956) 412-9500
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Patient Registration

Welcome to our office, please read and fill out carefully. We are happy to answer any questions you may have.

Name:_____ _____ _____ _____
Last First Mi Preferred Name

Gender: ○ Male ○ Female **Marital Status**: (circle one) Married Single Child Other

Home #: _____ **Cell #:** _____ **SS #:** _____ **DOB**: _____

Address: _____ **City, State, Zip Code:**_____

Email Address: _____ **Name of Employer:** _____

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

Whom may we thank for referring you? Dr._____ □ Google □ Newspaper □ Word of mouth

Dental Insurance: Yes ___ No ___ (circle one) Aetna Ameritas BCBS Delta Dental Guardian Humana MetLife Other:_____

Primary Dental Insurance:
Insurance Plan Name: _____
Insurance Provider Phone #: ( ) _____
Name of Insured: _____
Insured's DOB: __/_____/_____ SS #: ____-_____-_____
Insured's Employer Name: _____
Patient's Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Secondary Dental Insurance:
Insurance Plan Name: _____
Insurance Provider Phone #: ( ) _____
Name of Insured: _____
Insured's Birth Date: _____/_____/_____ SS # _____-____-_____
Insured's Employer Name: _____
Patient's relationship to Insured: ○Self ○Spouse ○Child ○Other

General health: Excellent _____ Good _____ Fair _____ Poor_____

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

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

Check 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?)

_____ _____ _____

_____ _____ _____

Office Use Only: BP: _____ P: _____

Medical History: Please make a check mark whether you now 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
□ TMJ	□ Thyroid	□ Liver Disease	□ Pacemaker
□ Stroke	□ Recent Weight Loss	□ Stomach Problems	□ Ulcers
□ Hives/Rash	□ Renal Dialysis	□ Lung Disease	
□ Venereal Disease	□ Drug Addiction	□ Other	

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

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

Women Only: Pregnant □ Yes □ No If yes, Due Date: _____

When did you have your last cleaning appointment? _____

Do you smoke? Yes □ No □ If yes, how often? _____

How often do you see your dentist? □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ 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 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 Name (Please Print): _____ Date: _____

Patient/Guardian Signature: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I was given the opportunity to read the Privacy Notice and object to disclosures of my protected health information.
I agree that I am financially responsible for all changes 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 the 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 the authorization to be used in place of the original.
HIPAA requires a dental practice to make a good faith effort to obtain a signed acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

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ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")
I acknowledge that I have received a copy of Cornerstone Periodontics HIPAA Notice of Privacy Practices.

_____ _____ _____
Patient Name (Please Print) Patient/Guardian Signature Date