Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ **Artificial Joints**
  Surgery Date:_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ CPAP Machine
- ☐ Daytime Sleepiness
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fatigue
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant** (current)
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy

OTHER:
_____

Please list or provide a list of all current medications:
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any blood thinners or bone density medications including bisphosphonates? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary-Dental

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary-Dental (if applicable)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Medical Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical, dental, and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to **CORNERSTONE FAMILY DENTISTRY**.

For Medical/Dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorization to Release Information

I hereby authorize CORNERSTONE FAMILY DENTISTRY:
To (1) release any information necessary regarding my illness and treatments to insurance carriers and/or any specialist I may be referred to;
(2) Process insurance claims generated in the course of examination or treatment; and
(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

I understand that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

This order will remain in effect until revoked by me in writing. I have requested medical services from: Cornerstone Family Dentistry

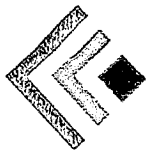
On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to Cornerstone Family Dentistry upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment of benefits is to be considered as valid as the original.

Patient/Responsible Party Signature _____ **Date** _____



CORNERSTONE

FAMILY DENTISTRY

Chris Leslie, DDS Clint Metcalf, DDS

Patient Contact

I give permission for the following communications to be used by Cornerstone Family Dentistry:
Please check all that apply

☐ Cell Phone ☐ Text Message
☐ Home Phone ☐ Work Phone ☐ E-Mail: _____

I am granting permission for Cornerstone Family Dentistry to leave a message with any person who may answer my phone or on my voicemail of the following:
Please check all that apply

☐ Cell Phone ☐ Home Phone ☐ Work Phone

Authorization for Release of Health Records

I would like to give permission for the following person(s) to have access to personal information including, but not limited to appointment, treatment, and billing of myself and my dependent children listed below.

Name of Recipient(s): _____

Relationship to the Patient: _____

Please list any dependent children (under age 18) also covered by this acknowledgement:

_____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Cornerstone Family Dentistry in writing.

Signature of Patient (or Patient Representative): _____ Date: _____

Printed Name of Patient (or Patient Representative): _____

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