Cornerstone
Dental & Orthodontics

## PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ DOB: _____ ☐ M or ☐ F

Home Address: _____ Apt #/ Unit: _____ City: _____ Zip code: _____

Home Number: _____ Cell Number: _____ Ok to send text message? ☐ Yes ☐ No

Email Address: _____ SSN: _____

## RESPONSIBLE PARTY

***Disregard if same as above** Relationship to Patient: _____

First Name: _____ MI: _____ Last Name: _____ DOB: _____ ☐ M or ☐ F

Home Address: _____ Apt #/ Unit: _____ City: _____ Zip code: _____

Home Number: _____ Cell Number: _____ Ok to send text message? ☐ Yes ☐ No

Email Address: _____ SSN: _____

## EMERGENCY CONTACT

First Name: _____ Last Name: _____ Relation: _____

Contact Number: _____ Work Number: _____ Contact Email: _____

## PRIMARY INSURANCE

Subscriber First Name: _____ MI: _____ Last Name: _____

Subscriber SSN: _____ DOB: _____ Relation to Pt: ☐ Self ☐ Spouse ☐ Child ☐ other

Employer: _____ Insurance Company: _____

Subscriber ID Number: _____ Group Number: _____ Effective Date: _____

INS Company phone number: _____ INS Company Address (if known): _____

## SECONDARY INSURANCE

Subscriber First Name: _____ MI: _____ Last Name: _____

Subscriber SSN: _____ DOB: _____ Relation to Pt: ☐ Self ☐ Spouse ☐ Child ☐ other

Employer: _____ Insurance Company: _____

Subscriber ID Number: _____ Group Number: _____ Effective Date: _____

INS Company phone number: _____ INS Company Address (if known): _____

## SIGNATURE

Financial Responsibility: *I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for service rendered, I am liable for the shortfall. I authorize the provider to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatments of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.*

Information Verification: *I certify that all information is complete and correct. I agree that Cornerstone Dental and Orthodontics, LLC (I.E. "C.D.O. LLC") or anyone else acting on its behalf may verify this information from any source it deems necessary including but not limited to obtaining credit reports and may provide others with information regarding credit history including credit report, contact information, and social security number to the extent permitted by law.* Consent to Use of Email Address/Telephone Numbers: *I agree that Cornerstone Dental and Orthodontics, LLC (I.E "C.D.O., LLC") to use such email address(es) for the purpose of servicing my account and/or sending me information about goods and services offered by sale by "C.D.O., LLC". I further agree that by providing my residential land line and/or cell phone number, I expressly consent to receiving prerecorded message calls and text messages from an automatic telephone dialing system for the purpose of servicing my account and/or telemarketing. I agree that the above consent applied to all telephone numbers provided herein as well as to any numbers I provide in the future. I understand that my consent to receive calls and text messages is not a condition of receiving treatment or purchasing any goods or services from Cornerstone Dental and Orthodontics, LLC.*

_____ _____ _____

*Signature of Patient, Parent, Guardian or Personal Representative* *Relationship to Patient* *Date*

# HEALTH HISTORY

## DENTAL HISTORY

Patient Name: _____

Reason for Today's Visit:_____ Date of last dental care: _____

**Mark ( X ) If you have had problems with any of the following:**

| | | | |
|---|---|---|---|
| ☐ Bad Breath | ☐ Food collection between teeth | ☐ Periodontal treatment | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Grinding teeth | ☐ Sores or growth in mouth | ☐ Sensitivity to cold |
| ☐ Clicking or popping of jaw | ☐ Loose teeth or broken fillings | ☐ Sensitivity when biting | ☐ Sensitivity to sweet |

How often do you floss? _____ How often do you brush? _____

## MEDICAL HISTORY

Physician's Name (PCP):_____ Date of last visit:_____

Preferred Pharmacy: _____ Address:_____

Have you had any serious illnesses or operations? If yes, please list with procedure and date: _____

Have you ever had a blood transfusion? If yes, please list dates: _____

Have you taken any group of drugs collectively referred to as "Fen-phen"? These include combinations of Lonimin, Adipex, Fastine (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramin). ☐ Yes ☐ No

Do you or have used Bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

**[Women]** Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

**Mark ( X )if you have or have had any of the following :**

| | | | |
|---|---|---|---|
| ☐ Abnormal Bleeding | ☐ Cortisone Treatments | ☐ Hepatitis (A, B, C or other): _____ | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Cough (Persistent) | ☐ High Blood Pressure | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough up blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Heart Valves | ☐ Dementia/Alzheimer's | ☐ Jaw Pain | ☐ Shortness of Breath |
| ☐ Artificial Joints: _____ | ☐ Diabetes | ☐ Kidney Disease | ☐ Sinus Problems |
| ☐ Asthma | ☐ Dialysis | ☐ Liver Disease | ☐ Stroke |
| ☐ Anxiety/Nervousness | ☐ Difficulty breathing | ☐ Mental Health Treatment | ☐ Swelling of Feet |
| ☐ Blood Disease | ☐ Epilepsy | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Cancer | ☐ Fainting | ☐ Numbness or Muscle Weakness | ☐ Tobacco Habit |
| ☐ Chemical Dependency | ☐ Glaucoma | ☐ Organ Transplant | ☐ Tonsillitis |
| ☐ Chemotherapy | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Circulatory Problems | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Cold Sores/Canker Sores | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |

*****Do you have any other medical conditions not already listed above?** _____

## MEDICATIONS

List of current medications:

_____

_____

## ALLERGIES

| | |
|---|---|
| ☐ Aspirin | ☐ Latex |
| ☐ Barbiturates | ☐ Metals/Nickels/Jewelry |
| ☐ Codeine | ☐ Penicillin/Other Antibiotic: _____ |
| ☐ Dental Anesthetic | ☐ Sulfa Drugs |
| ☐ Iodine | ☐ Other: _____ |

## SOCIAL

Do you use alcohol? ☐ Yes- How often? _____ ☐ No Do you use recreational drugs? ☐ Yes- How often? _____ ☐ No

## SIGNATURE

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.*

_____ _____ _____

*Signature of Patient, Parent, Guardian or Personal Representative* *Relationship to Patient* *Date*

# OFFICE POLICIES AND PROCEDURES

Thank you for choosing Cornerstone Dental and Orthodontics, LLC. to serve your dental care needs.
We strive to provide high quality care to our patients and are committed to your treatment being successful.

***Please read and sign at the bottom acknowledging that you were informed of these policies. Let us know if you have questions about any of our office polices. Thank you!***

## FINANCIAL POLICY

On your first visit we expect you to supply our office with your insurance information and photo ID card. If any changes should occur during the time you are a patient, **it is your responsibility to inform our office of any changes (personal information, insurance information, etc.) Our office is not responsible for claims submitted to insurance companies by which you are no longer covered**.

New patients are required to pay for services in full on their first visit. If the patient is a member of an HMO/DMO (not in network) plan, the patient portion/co-payment is due. **Patients are required to pay their deductible, co-payments, or estimated patient portion due on the day of visit/service.**

While we accept most insurance plans and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to appointment and estimate your portion of the bill. **We ask that you pay your patient portion of the bill at the time of service.** Even though you may have an insurance claim pending, you will receive a statement for the outstanding balance on your account. **We cannot accept responsibility for collecting an insurance claim after 60 days or negotiating a disputed claim. Insurance policies are a contract between you, your employer, and the insurance carrier. Please be aware that some, and perhaps all, of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.**

If no payment is received on an account after two monthly statements, our office will make every effort to contact the responsible party indicated on page one. If the responsible party cannot be reached, a third bill will be sent stating that "This will be the final notice for payment". If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

**Financial options are available to all patients; please feel free to ask one of our office personnel.**

## FAILED OR CANCELED APPOINTMENTS

If an appointment has been reserved for you**, we kindly ask that patients give twenty-four hours' notice for cancellations; otherwise, we reserve the right to charge a minimum of $50 per half hour, which is currently our broken appointment fee**. The length of time reserved and the number of prior failed appointments will determine actual charges. **We will not offer appointments to patients who fail multiple appointments without having given proper notice.**

_____ _____ _____

*Signature of Patient, Parent, Guardian or Personal Representative* *Relationship to Patient* *Date*

## ESTIMATES AND FEES

After X-rays and examination, you are entitled to, and should ask for, an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis. Unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

## DELINQUENT ACCOUNTS

Delinquent accounts will be turned over to a Credit Reporting Collection Agency.

## NOTICE OF PRIVACY PRACTICE (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

## AUTHORIZATION TO RELEASE INFORMATION

*I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding my account.*

_____ _____

Name Relationship

_____ _____

Name Relationship

## SIGNATURE

_____ _____ _____

*Signature of Patient, Parent, Guardian, or Personal Representative* *Relationship to Patient* *Date*