CORNERSTONE
• DENTAL •

# PATIENT INFORMATION

First Name: Last Name: Middle Initial:

Patient is: ◯ Policy Holder ◯ Responsible Party Preferred Name:

## Responsible Party
( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Drivers License:

◯ Responsible Party is also a Policy Holder ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

## Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via email.

Birth Date: Age: Social Security: Drivers License:

Sex: ◯ Male ◯ Female Martial Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Comments:

## Primary Insurance Information

Name of Insured:

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child

Insured Social Security:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: Rem Deductible:

## Secondary Insurance Information

Name of Insured:

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child

Insured Social Security:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: Rem Deductible:

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# TAKE OUR *Smile Assessment*

**AND SEE IF YOU MIGHT BE A CANDIDATE FOR AN ENHANCED SMILE.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Are you comfortable showing your teeth when you smile? |
| ☐ | ☐ | Are you happy with the appearance of your teeth? |
| ☐ | ☐ | Do you have unsightly crowns or fillings? |
| ☐ | ☐ | Are your gums or teeth sensitive? |
| ☐ | ☐ | Do you feel your teeth are too long? |
| ☐ | ☐ | Do you feel your teeth are too short? |
| ☐ | ☐ | Do you like the color of your teeth? |
| ☐ | ☐ | Are you missing teeth? |
| ☐ | ☐ | Are you interested in improving the appearance of your teeth? |
| ☐ | ☐ | Are you familiar with the benefits of dental implants? |
| ☐ | ☐ | Are your gums receding? |
| ☐ | ☐ | Are you anxious or fearful of treatment? |
| ☐ | ☐ | Are you happy with the alignment of your teeth? |
| ☐ | ☐ | Is fear holding you back from a perfect smile? |
| ☐ | ☐ | Is lack of time holding you back from a perfect smile? |
| ☐ | ☐ | Is cost holding you back from a perfect smile? |
| ☐ | ☐ | Is there something else holding you back from a perfect smile? |

**Please feel free to explain any answers:**

_____

_____

_____

3030 49th Street South • Fargo, ND 58104 • (701) 237.3583 P • (701) 237.4159 F • www.cstonedentalfargo.com

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# MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

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**Patient Name:** _____ **Birth Date:** _____

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No If yes, please explain: _____

Have you ever taken, Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ❍ Yes ❍ No If yes, please explain: _____

Are you on a special diet? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No If yes, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____

## Women: Are You

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

## Allergies:

Are you allergic to any of the following: ❍ Asprin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Sulfa Drugs

❍ Other: _____ If yes, please explain: _____

## Do you have, or have you had, any of the following:

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ❍ Yes ❍ No | Cortisone Medicine ❍ Yes ❍ No | Hemophilia ❍ Yes ❍ No | Renal Dialysis ❍ Yes ❍ No |
| Alzheimer's Disease ❍ Yes ❍ No | Diabetes ❍ Yes ❍ No | Hepatitis A ❍ Yes ❍ No | Rheumatic Fever ❍ Yes ❍ No |
| Anaphylaxis ❍ Yes ❍ No | Drug Addiction ❍ Yes ❍ No | Hepatitis B or C ❍ Yes ❍ No | Rheumatism ❍ Yes ❍ No |
| Anemia ❍ Yes ❍ No | Easily Winded ❍ Yes ❍ No | Herpes ❍ Yes ❍ No | Scarlet Fever ❍ Yes ❍ No |
| Angina ❍ Yes ❍ No | Emphysema ❍ Yes ❍ No | High Blood Pressure ❍ Yes ❍ No | Shingles ❍ Yes ❍ No |
| Arthritis/Gout ❍ Yes ❍ No | Epilepsy or Seizures ❍ Yes ❍ No | High Cholesterol ❍ Yes ❍ No | Sickle Cell Disease ❍ Yes ❍ No |
| Artificial Heart Valve ❍ Yes ❍ No | Excessive Bleeding ❍ Yes ❍ No | Hives or Rash ❍ Yes ❍ No | Sinus Trouble ❍ Yes ❍ No |
| Artificial Joint ❍ Yes ❍ No | Excessive Thirst ❍ Yes ❍ No | Hypoglycemia ❍ Yes ❍ No | Spina Bifida ❍ Yes ❍ No |
| Asthma ❍ Yes ❍ No | Fainting Spells/Dizziness ❍ Yes ❍ No | Irregular Heartbeat ❍ Yes ❍ No | Stomach/Intestinal Dis. ❍ Yes ❍ No |
| Blood Disease ❍ Yes ❍ No | Frequent Cough ❍ Yes ❍ No | Kidney Problems ❍ Yes ❍ No | Stroke ❍ Yes ❍ No |
| Blood Transfusion ❍ Yes ❍ No | Frequent Diarrhea ❍ Yes ❍ No | Leukemia ❍ Yes ❍ No | Swelling of Limbs ❍ Yes ❍ No |
| Breathing Problems ❍ Yes ❍ No | Frequent Headaches ❍ Yes ❍ No | Liver Disease ❍ Yes ❍ No | Thyroid Disease ❍ Yes ❍ No |
| Bruise Easily ❍ Yes ❍ No | Genital Herpes ❍ Yes ❍ No | Low Blood Pressure ❍ Yes ❍ No | Tonsillitis ❍ Yes ❍ No |
| Cancer ❍ Yes ❍ No | Glaucoma ❍ Yes ❍ No | Lung Disease ❍ Yes ❍ No | Tuberculosis ❍ Yes ❍ No |
| Chemotherapy ❍ Yes ❍ No | Hay Fever ❍ Yes ❍ No | Mitral Valve Prolapse ❍ Yes ❍ No | Tumors or Growths ❍ Yes ❍ No |
| Chest Pains ❍ Yes ❍ No | Heart Attack/Failure ❍ Yes ❍ No | Pain in Jaw Joints ❍ Yes ❍ No | Ulcers ❍ Yes ❍ No |
| Cold Sores/Fever Blisters ❍ Yes ❍ No | Heart Murmur ❍ Yes ❍ No | Parathyroid Disease ❍ Yes ❍ No | Venereal Disease ❍ Yes ❍ No |
| Congenital Heart Dis. ❍ Yes ❍ No | Heart Pacemaker ❍ Yes ❍ No | Psychiatric Care ❍ Yes ❍ No | Yellow Jaundice ❍ Yes ❍ No |
| Convulsions ❍ Yes ❍ No | Heart Trouble/Disease ❍ Yes ❍ No | Radiation Treatments ❍ Yes ❍ No | |
| | | Recent Weight Loss ❍ Yes ❍ No | |

Have you ever had any serious illness not listed above: ❍ Yes ❍ No _____

Additional Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

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# CORNERSTONE DENTAL

## Payment Options for Our Valued Patients

**As the recipient of our services, you are ultimately responsible for the charges incurred during your treatment. You may have insurance or another form of financial support, but you remain legally responsible for your bill.**

## Self-Pay

- Payment for services is due on the day you receive the services.

We do offer a 5% discount when paying with cash or check. We also accept VISA, MasterCard or Discover Card.

## Insurance

- As a courtesy, our office will complete and submit dental insurance claims on your behalf. We will work diligently to achieve the maximum reimbursement as quickly as possible. A 'Patient Portion Due' or PPD amount will be provided to you and collected in our office at the completion of services. Please understand that this amount is an estimate and is not a guarantee that your insurance will pay exactly as estimated. Pre-authorizations to your insurance company can be completed upon request or recommendation.

## Third-Party Financing

If you don't have dental insurance, or if you do receive coverage but still need a little assistance comfortably affording your dental care, our office works with third-party financiers that help you make convenient payments on your dental bills.

- Compassionate Finance
- CareCredit
- Lending Club

More information available upon request

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# Cornerstone Dental Group

3030 49th St. S
Fargo, ND 58104-4229
(701) 237-3583
Fax: (701) 237-4159

Please release my dental records to Dr: _____

(*Note-we prefer to email our digital x-rays-please supply an email address whenever possible)

E-Mail: _____

Address: _____

City: _____

State: _____

Phone: _____

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____