Adult Health History and Registration

Name_____ Male____ Female____ Today's Date_____

Birth Date_____/_____/_____ E-Mail Address:_____

Home Address_____ City_____State_____Zip_____

Home #_____ Cell #_____ SS # _____-_____-_____

Employer_____ Employer Phone _____

Employer Address _____ City_____ State _____ Zip _____

Single_____ Married_____ Divorced_____ Widowed_____

Spouse's Name_____ Birth Date_____/_____/_____

Spouse Employer_____ Employer Phone #_____

Emergency Contact_____ Relationship_____ Phone #_____

How did you hear about our office? _____

Medical Info: Current Weight_____lbs. Preferred Pharmacy_____ City_____

Do you use tobacco?_____ If yes, what kind (snuff, chew, cigarettes, etc.)?_____ How Many Years? _____

Date of Last Dental Visit_____ Reason for today's visit?_____

Are you allergic to:

Codeine Yes___ No___
Aspirin Yes___ No___
Penicillin Yes___ No___
Latex Yes___ No___
Sulfa Yes___ No___
Other (List): _____

Do You Have / Have a History of:

Diabetes Yes___ No___
High Blood Pressure Yes___ No___
Heart Treatment Yes___ No___
Joint Replacement Yes___ No___
Bisphosphonate Use Yes___ No___
(examples: *Fosamax, Boniva, Actonel, Aredia, Zometa*)

*****LIST ALL CURRENT MEDICATIONS***:**_____

_____

_____

WOMEN ONLY:

Are you or could you be pregnant? Yes____No____ Nursing/Breastfeeding? Yes____ No____

DO YOU HAVE OR IS THERE ANY PERSONAL HISTORY OF THE FOLLOWING?

Heart Disease Y N
Endocarditis Y N
Prosthetic Heart Valve Y N
Prosthetic Joint Y N
Year Placed_____
Heart Murmur Y N
High Blood Pressure Y N
Last Known_____
Pacemaker Y N
Liver Disease Y N
Chronic Hepatitis Y N
TB Y N
Ulcer Y N

Kidney Disease, Dialysis, or Transplant Y N
Immune System Disease, AIDS, or HIV Infection Y N
Asthma or Breathing Difficulty Y N
Diabetes Y N
Arthritis Y N
Abnormal Bleeding Y N
Fainting or Seizures Y N
Psychiatric Treatment Y N
Problems with Sleep/Snoring Y N
Had a sleep study? Y N

Canker sores (inside mouth) Y N
Cold Sores (on lips) Y N
Grinding or Clenching of Teeth Y N
Headaches on waking in morning Y N
Cancer History Y N
If yes, locations involved:
_____
Do you take herbal supplements? Y N
Please list:_____
_____

Do you think your mouth is affecting your overall health in a negative way? Y N

Do you wish you could change the appearance of your smile? Y N

Do your gums bleed easily, feel tender, or irritated? Y N

Do you have a physician? Y N Name:_____ Location:_____

Preferred Payment Method and Account Information:

Private Pay_____ Other (such as Power of Attorney) _____

Insurance: _____ - *please fill in the following box-* Is there Secondary Insurance? _____

Dental Ins. Group/Plan #_____ ID #_____Name of Guarantor_____Phone_____

Address_____ City_____ State_____Zip_____ Soc. Security #_____-____-_____

Names of Insured under Primary Plan:_____

What would you say is/are the primary reasons you selected our office for care? *circle up to 3*

My friend/ family recommended High Tech CEREC One-Visit Crowns Relaxing Treatment

Computer Controlled Anesthesia Laughing Gas Pleasant office staff Doctors extra education/ awards

Payment Policies

Payment is expected when services are rendered unless other arrangements are made in advance.
Payment may be made with cash, personal check, MasterCard, VISA, Discover or American Express.

Two arrangements are available for deferred payment (with approval):

1-Simple billing: A statement will be sent, usually around the 25th of the month. It is due in full by the *next* billing cycle. Any unpaid balance will be subject to a billing charge of **$5 per statement**, or a finance charge of 1.39% per month, (18% expressed as an Annual Percentage Rate [APR]), whichever is greater.

2-For complex treatment plans: Payment may be made over 3 months with no interest or billing charge. After 3 billing cycles the balance will be *due in full and subject to finance charges* as explained above.

Insurance: In cases where we have accepted assignment of benefits, you will be billed for your estimated portion. You will have 30 days to pay, after which finance charges will begin as explained above.

Costs of Collection: If we refer the collection of your account to an attorney, you agree to pay our reasonable attorney's fees, court costs or other collection costs as permitted by law.

Everyone at Cornerstone Dental Health strives to improve patient care through continuing education and case studies of treatment. Before and after photos are sometimes required during treatment to properly document conditions. Additionally, doctors Moon and Obrock often teach at educational meetings and would appreciate your permission to use these photos. Patients are never identified, and your privacy is protected as personal health information and is never shared under any circumstances. If you object to the use of any photos for teaching purposes initial here ____ .

I have read and understand the terms and policies set forth in "Payment Policies" as outlined above, and agree to abide by them. I have read and answered all health history questions to the best of my knowledge. I understand it is my responsibility to inform on any changes/additions to this history at the time of such changes and prior to planned treatment is completed.

Signature: _____ **Date**:_____