CORNERSTONE
DENTAL

NP REGISTRATION / MEDICAL HISTORY

NAME: Last _____ **First** _____ **MI** _____

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

Address: Street _____

City:_____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:**_____

Email:_____

Preferred method of contact for appointments: ☐ **TEXT** ☐ **EMAIL** ☐ **PHONE CALL** ☐ **DO NOT CONTACT**

Social Security # _____ **Occupation** _____

Referred by _____

INSURANCE INFORMATION

Insured's Name _____ **Insured's ID or SSN** _____
Insurance Company _____ **Group #** _____ **Local #** _____
Insurance Company Address _____ **Phone #** _____
Insured's Employer _____
Duel Coverage? Yes _____ **No** _____ **Insured's D.O.B.** _____
If Yes:

Insured's Name _____ **Insured's ID or SSN** _____
Insurance Company _____ **Group #** _____ **Local #** _____
Insurance Company Address _____ **Phone #** _____
Insured's Employer _____
Insured's D.O.B. _____

COLLEGE INFORMATION

Full Time or Part Time Student?_____

School Name : _____ **State:** _____

Signature on File

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, (Name of Insured) _____ hereby authorizer (Name of Insurance Company) _____, to pay and hereby assign directly to Cornerstone Dental all dental benefits, if any, otherwise payable to me for services described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Cornerstone Dental. Authorization is hereby given to release all information necessary to the payment of said benefits.

Signature:_____ **Date:** _____
(Authorized Signature of Covered Person / Employee)

MEDICAL HISTORY

PHYSICIAN:_____**CLINIC:**_____

EMERGENCY CONTACT: _____ **PHONE # :**_____

Yes No Any change in your health in the last two years? _____

Yes No Are you currently under the care of a Physician? Describe _____

Yes No Have you ever had any surgery of any kind? Describe _____

Yes No Have you ever been transfused?_____

Yes No Have you been advised by a physician for the need of any medical treatment? Describe: _____

_____

ARE YOU CURRENTLY OR HAVE YOU BEEN PREVIOUSLY BEEN TREATED FOR ANY OF THE FOLLOWING?

Yes No Arthritis
Yes No Rheumatic Fever
Yes No Heart Problems
Yes No High Blood Pressure
Yes No Anemia, Sickle Cell Disease
Yes No Epilepsy, Seizures
Yes No Fainting Spells
Yes No Diabetes
Yes No Hepatitis
Yes No Ulcers
Yes No Kidney Disorders
Yes No AIDS
Yes No Chemical Dependency
Yes No Thyroid Condition
Yes No Venereal Disease
Yes No Pacemaker
Yes No Joint Replacement
Yes No Allergies
Yes No Radiation of Chemical Therapy
Yes No Sinus Problems
Yes No Asthma
Yes No Bleeding Disorders
Yes No Heart murmur
Yes No Mitral Valve Prolapse
Yes No Tuberculosis
Yes No Latex Sensitivity

Yes No Have you ever had an allergic reaction to or been told not to take any medications? If yes, what medications:_____

Yes No Are you currently taking any medications? _____

_____

_____

Yes No Are you Pregnant? Anticipated delivery date: _____

Yes No Do you use any tobacco products? Daily intake _____

I certify the above to be true and correct to the best of my knowledge.

Signature _____ **Date** _____
(Parent or Guardian of Minor)