CORNERSTONE DENTAL ASSOCIATES
The Center for Oral Health

Patient Information

Patient Name:_____ Today's Date:_____

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Prefered Name:_____

Maritial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Sex: ☐ Male ☐ Female

Address:_____

Social Security #:_____ Date of Birth:_____

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

Drivers License #:_____ State:_____ Email Address: _____

Employment Information

Patient Employed By:_____ Occupation:_____ Phone:_____

Work Mailing Address:_____

Emergency Contact Information

Emergency Contact Name:_____ Emergency Contact Phone:_____

Relationship to Patient:_____

Minor Patient Information

Is the patient a minor? ☐ Yes ☐ No Full-time Student? ☐ Yes ☐ No Name of School:_____

Name of Responsible Party:_____ Date of Birth:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Address *(if different from patient)*:_____

Phone *(if different from patient)*:_____

Primary residency: ☐ Both Parents ☐ Mother ☐ Father ☐ Step-parent ☐ Shared Custody ☐ Guardian

Dental Benefit Plan Information

Employer *(if different from above)*:_____ Occupation:_____ Phone:_____

Address:_____

Primary Dental Plan Name:_____ Phone:_____

Address:_____

Name of Insured:_____ Date of Birth:_____ ID Number:_____

Policy Number:_____ Patient Relationship to Insured:_____

Secondary Dental Plan Name:_____ Phone:_____

Address:_____

Name of Insured:_____ Date of Birth:_____ ID Number:_____

Policy Number:_____ Patient Relationship to Insured:_____

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Request and Consent for General Treatment – Adult

I request and authorize the dentist and his/her choice of assistant and hygienist to perform my treatment plan. I have had the opportunity to discuss with the Doctor my medical history indicating any serious problems, injuries, or allergies. I have had explained to me and have had sufficient opportunity to discuss my dental conditions, planned procedures and treatments, and the benefits to be reasonably expected from this treatment compared with alternative approaches and no treatment.

I request and authorize the taking of oral-dental x-rays as may be considered necessary or advisable by the dentist to diagnose and treat my dental problem.

I understand that antibiotics, analgesics, and other medications can cause drowsiness, lack of coordination, nausea, redness, swelling of tissues, pain, and itching, vomiting, and there may be a possibility of a severe allergic reaction known as anaphylactic shock. Local anesthesia can cause a tingling sensation in the lip, chin, tongue, cheek, teeth or gums that could be temporary or permanent. If any of these symptoms occur, I will contact the doctor's office immediately. It is also not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may administer or prescribe. Alcohol may also increase these effects. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other additional contraceptive measures be taken during the time of administration.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give permission to make any changes and additions necessary.

I understand that some dental procedures may cause changes in occlusion (biting), jaw or muscle cramps, spasms, difficulty with the jaw, referred pain to the ear and/or neck. I understand that there is always a possibility of delayed healing and/or treatment failure. I give permission for the doctor to make changes and adjustments necessary.

The usual and most frequent risks or complications include, but are not limited to, the possibility of pain or discomfort during and following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a transient or permanent temporomandibular (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

All of my questions have been answered to my satisfaction and I consent to general treatment.

_____ _____

Signature of Person Consenting to Treatment *Date*

_____ _____

Signature of Dentist *Date*

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Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Cornerstone Dental Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information	Description of Information to be Released
_____ Voicemail	_____ Results of xrays/diagnosis
_____ Spouse	_____ Other
_____ Parent (Provide Name)	_____ Financial Information
_____	_____ Dental Needs as Follows _____
_____ Other (Provide Name)	_____ Financial Information
_____	_____ Dental Needs as Follows _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have to right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative (Description of Rep's Authority) (Attach Documentation) *Date*

CORNERSTONE DENTAL ASSOCIATES

Eaglesoft Medical History

Patient Name:_____ Birth Date:_____ Today's Date:_____

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.

Are you under a physican's care now? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐Yes ☐ No _____

Do you use tobacco? ☐Yes ☐ No _____

Do you use controlled substances? ☐Yes ☐ No _____

Women: Are you... ☐ Pregnant / Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other _____

Do you have or have you had any of the following?

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

Have you ever had any serious illness not listed? ☐ Yes ☐ No _____

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:

X_____ **Date:**_____

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The Center for Oral Health

Financial Policy and Authorizations

We are committed to providing you with the best possible care. We would like to explain your financial and scheduling responsibilities with our practice.

Patient Responsibilities: Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office we strive to maximize your insurance benefits and make any remaining balance easily affordable. Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of any treatment with our practice. We accept the following forms of payment. Cash, Check, Credit/Debit and Care Credit.

Our fees are based on the quality materials we use and the time, effort, and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit estimate before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve your best oral health. Ultimately, however, you are responsible for any balance left after Insurance.

Our Practice is not a contracted provider with your dental benefit plan. We are a Delta Dental Premiere provider. It is the patients responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers.

Reservation Policy: Our Practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. To maintain the utmost service and care, we do require 48-hours' notice to reschedule an appointment. With less than 48-hours' notice, a deposit to reserve the appointment time again may be required. To serve all of our patients in a timely manner we may need to reschedule an appointment if a patient is 10 minutes late or more arriving to our practice.

Authorizations:

_____ *Initial* I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

_____ *Initial* I authorize the release of information necessary to process my dental benefits claims. I hereby authorize payment directly to this doctor otherwise payable to me. The dental practice may contact me via phone, text email to provide information such as appointment reminders and information about treatment, payment, my account or insurance using automated equipment.

_____ *Initial* I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_____ *Initial* I have read the above and agree to financial and scheduling terms.

_____ _____

Signature *Date*

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Records Release Authorization Form

I,_____ (Date of Birth:_____), hereby authorize the office of, or other necessary parties_____ to release dental x-rays and copies of such as follows: Bitewings and periapical x-rays taken within the past year, panoramic or full mouth series taken within the past 5 years to the following office:

Please email to: teresa@cornerstonedentists.com or nicole@cornerstonedentists.com

Cornerstone Dental Associates
Lutz-Craver, Karner and Associates
101 Life Enrichment Blvd.
Shelby, NC 28150

Signature of Patient/Parent/Guardian:_____

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign the authorization and that my treatment will not be conditioned on signing.