PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

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

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

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

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

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.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

MEDICAL HISTORY

PATIENT NAME _____ Birth 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 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 _____
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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ 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	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ 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 _____ DATE _____

CORNERSTONE DENTAL

Dr. John Kromhout
353 W. Olentangy St., Powell, OH 43065
614.477.0535
www.cornerstonedentalpowell.com

_____
Patient Name

Dental History

Please take a few minutes to answer the following questions about your dental health. Our goal is to provide Complete Health Dentistry for each patient and this information will allow us to treat you on a more personalized basis. Your answers are for our records only and will be considered confidential.

Today's Date: _____

How would you like to be addressed? _____

Approximately when was your last dental appointment? _____

What dental problems have you had in the past? _____

What dental problems are you currently experiencing? _____

How do these problems affect you? _____

What were your previous dental experiences like? _____

What are your thoughts about going to the dentist? _____

I think my present state of dental health is: ○ Excellent ○ Good ○ Fair ○ Poor

What are your goals regarding your dental health ? ○ Pain Free ○ Bright White Smile ○ Healthy Gums ○ Straighter Teeth ○ Keeping Your Natural Teeth for a Lifetime ○ Fresh Breath ○ Other_____

Do you have or have you had orthodontic treatment? _____

Which of the following home care implements do you use?

Manual Toothbrush	○ Yes	○ No	How Often? _____	Dental Floss	○ Yes	○ No	How Often? _____
Powered Toothbrush	○ Yes	○ No	How Often? _____	Home Fluoride	○ Yes	○ No	How Often? _____
Interproximal Device	○ Yes	○ No	How Often? _____	Mouth Rinse	○ Yes	○ No	How Often? _____

Patient or Guardian Signature _____ Date _____

CORNERSTONE DENTAL

Dr. John Kromhout
353 W. Olentangy St., Powell, OH 43065
614.477.0535
www.cornerstonedentalpowell.com

_____
Patient Name

Smile Evaluation

Many of our patients have expressed an interest in improving the appearance of their smile. In order to better serve the wants and needs of our patients, we have developed the following questionnaire. If you have ever desired a more attractive smile, please take a few moments to answer the following questions.

1. Is the appearance of your smile satisfactory to you? ○ Yes ○ No
2. Do your teeth appear to be out of alignment? ○ Yes ○ No
3. Are you concerned about any spaces between your teeth? ○ Yes ○ No
4. Are you satisfied with the color of your teeth? ○ Yes ○ No
5. Do you like the shape of your teeth? ○ Yes ○ No
6. Are you concerned about the appearance of old silver fillings or other dental work?
   ○ Yes ○ No
7. Are you concerned about any of the following:
   ○ Chipped teeth
   ○ Protruding teeth
   ○ Overlapping teeth
   ○ Crowded teeth
8. Please list any additional comments or questions that you may have about your smile or cosmetic dental procedures

   _____
   _____
   _____
   _____

CORNERSTONE DENTAL

Please list all medications taken on a regular basis

Today's Date_____/_____/_____

Name (Last)_____(First) _____(M.I.)____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

CORNERSTONE DENTAL

Patient Consent

I authorize Dr. John C. Kromhout and the staff of Cornerstone Dental to obtain x-rays, photographs or other necessary diagnostic aids to make a thorough analysis of my oral health. I will have the opportunity to discuss my treatment plan with Dr. Kromhout and financial arrangements will be agreed upon *before* commencing treatment.

Dental Insurance

As a courtesy to our patients, we will file your dental insurance claim and attempt to maximize any benefits available to you. **We cannot guarantee any estimated coverage**. Please be aware that we may not be an in-network provider with your insurance company and you may incur an additional co-payment. You will be expected to pay your estimated percentage the day the services are performed. Please keep in mind that we can only offer an estimate of your out-of-pocket portion. If there is a difference after insurance pays, you are responsible for the balance.

Payment Options and Financial Responsibility

Cornerstone Dental accepts Visa, MasterCard and Discover.

We offer an extended payment plan through **CareCredit** for patients who desire a monthly payment for treatment plans over $500. This is a line of credit that, upon approval, offers low monthly payments and special financing.

There is a $25 charge for all returned checks.

Payments that extend beyond 30 days from the first billing statement will accrue interest at a rate of 1.5% per month of the unpaid balance.

Appointment Policy

Cornerstone Dental aims to provide the best service to our patients; as such, we see patients on an appointment basis. We recognize that our patient's time is valuable and keep waiting time to a minimum. We expect the same courtesy from our patients. If you are unable to keep your appointment time, we request **48 hours** notice so we can accommodate another patient at that time. We reserve the right to charge a missed appointment fee for appointments that are cancelled without advanced notice.

CORNERSTONE DENTAL

Please sign below acknowledging your acceptance:

I understand the appointment policy, insurance guidelines and financial responsibilities of Cornerstone Dental.

I acknowledge that I have been provided a copy of the HIPPA Notice of Privacy Practices. My signature only represents my receipt of this notice.

I authorize Cornerstone Dental to use x-rays or photographs of my treatment for the purpose of publication and/or teaching.

Print Full Name

Signature Date