cornerstone DENTISTRY
modern, cosmetic excellence

CornerstoneCosmeticDentistry.com
1530 Lake St• Roselle, IL 60172
(630) 529-0900

Patient Information

Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone( ) _____ **Cell Phone ( )** _____ **Social Security Number:** ___ - ___ - ___
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School: _____ Spouse or Parent's Name: _____
Email: _____ Employer: _____
Person to contact in case of emergency: _____ Phone: _____
How did you hear about our office? ☐ Mailer/Ad ☐ Driving By ☐ Internet ☐ Insurance ☐ Friend: _____
☐ **Other:** _____

Dental History

Do you have a specific dental problem? Describe: _____
When was your last dental exam? _____
Name of previous dentist (optional)? _____
Do you ever have clicking, popping or discomfort in your jaw? _____
Please rate your smile from 1-10 (1 being unhappy and 10 being satisfied/confident): _____
Are your teeth sensitive to hot and cold? _____
Would you like to have whiter teeth? _____

Medical History

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	High/Low Blood Pressure	☐	☐	Cancer	☐	☐	Epilepsy or Seizures	☐	☐
OCD	☐	☐	Anxiety	☐	☐	Depression	☐	☐	Cardiomyopathy	☐	☐
Heart Murmur/Defect	☐	☐	Bacterial Endocarditis	☐	☐	Chemotherapy	☐	☐	Glaucoma	☐	☐
Angina/Chest Pain	☐	☐	Pace Maker	☐	☐	Osteoporosis	☐	☐	Artificial Joints	☐	☐
Heart Attack/Failure	☐	☐	Coronary Stent	☐	☐	Diabetes	☐	☐	Thyroid Disease	☐	☐
Congenital Heart Defect	☐	☐	Clotting problems	☐	☐	Aids/HIV infection	☐	☐	Tuberculosis	☐	☐
Mitral Valve Prolapse	☐	☐	Lung Disease	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Pulmonary Shunt	☐	☐	Hepatitis A, B, or C	☐	☐	Asthma	☐	☐
Artificial Heart Valve	☐	☐	Sinus Problem	☐	☐	Kidney Disease	☐	☐	Anemia	☐	☐
Pregnant	☐	☐	Medication for bones	☐	☐	Herpes/Cold Sores	☐	☐	Smoke/Tobacco	☐	☐

Are you allergic to any of the following? ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Epinephrine ☐ Other _____
Please list all other medical conditions: _____
Please list your current medications: _____

I certify that the information I have given is complete and correct to the best of my knowledge.

SIGNED: _____ **DATE:** _____

Financial & Cancellation Policy

*As a courtesy to you, we will file claims with your dental insurance carrier on your behalf. Any portion not covered by insurance is your responsibility. Co-payment is due on the date of service unless other arrangements are made. Canceled appointments with **less** than 24hour notice are subject to a **$30 cancellation fee**.*

I authorize my insurance company to directly pay Cornerstone Dentistry the insurance benefits otherwise payable to me. I also authorize them to release any information they deem necessary in connection with my treatment and/or the treatment of my children to my insurance company and/or other health practitioners

SIGNED: _____ **DATE:** _____

Our office is HIPAA (Health Insurance Portability and Accountability Act) compliant. To comply with one of HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. By signing below, you acknowledge you have received a copy of the Notice of Privacy Practices.

SIGNED: _____ **DATE:** _____