Patient Name: _____ Date of Birth: (Day)_____(Month)_____(Year)_____

Contact Numbers: (H): _____ (W): _____ (C): _____

Home Address: _____ City: _____

Postal Code: _____ Email address:_____

Emergency Contact (Name/Relationship): _____ Contact Number(s): _____

Referred By: _____

APPOINTMENT AGREEMENT

While visiting our team at Cornerstone Dental, recommended treatment is often of an urgent nature. The sooner we can diagnose and treat dental disease, the better it will be for your oral health. In addition, we understand that at times dental emergencies may arise that require immediate attention. Whatever your needs may be, we promise we will do our best to see you as soon as possible.

Trying to accommodate every patient's individual needs can be difficult. A scheduled appointment is a commitment of time between each of us. When appointments are cancelled, time that was reserved will be permanently lost. Cancelled appointments make it very difficult to provide timely service to our patients.

We request that when an appointment is made, that you make every effort to keep that commitment. Should a conflict arise, please provide us with two business days' notice to avoid a cancellation fee. We know that as our patients keep this commitment, we are better able to provide for their dental needs.

_____

Patient Signature

_____

Date

MEDICAL HISTORY

Name of Physician: _____ Contact # _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? ___ Excellent ___ Good ___ Fair ___Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury _____		
2. An allergic reaction to		
___ aspirin, ibuprofen, acetaminophen, codeine		
___ penicillin		
___ erythromycin		
___ tetracycline		
___ sulfa		
___ local anesthetic		
___ fluoride		
___ metals (nickel, gold, silver, _____)		
___ latex		
___ other		
3. heart problems, or cardiac stent within the last six months _____		
4. history of infective endocarditis _____		
5. artificial heart valve, repaired heart defect _____		
6. pacemaker or implantable defibrillator _____		
7. artificial prosthesis (heart valve or joints) _____		
8. rheumatic or scarlet fever _____		
9. high or low blood pressure _____		
10. a stroke (taking blood thinners) _____		
11. anemia or other blood pressure _____		
12. prolonged bleeding due to a slight cut _____		
13. emphysema, shortness of breath, sarcoidosis _____		
14. tuberculosis, measles, chicken pox _____		
15. asthma _____		
16. breathing or sleep problems (i.e. sleep apnea, snoring) _____		
17. kidney disease _____		
18. liver disease _____		
19. jaundice _____		
20. thyroid, parathyroid disease, or calcium deficiency _____		
21. hormone deficiency _____		
22. high cholesterol or taking statin drugs _____		
23. diabetes _____		
24. stomach or duodenal ulcer _____		
25. digestive disorders (i.e. celiac disease, gastric reflux) _____		

	YES	NO
26. osteoporosis / osteopenia (i.e. taking bisphosphonates) _____		
27.arthritis, rheumatoid arthritis, lupus _____		
28. glaucoma _____		
29. contact lenses _____		
30. head or neck injuries _____		
31. epilepsy, convulsions (seizures) _____		
32. neurologic disorders (ADD/ADHD, prion disease) _____		
33. viral infections and cold sores_____		
34. any lumps or swelling in the mouth _____		
35. hives, skin rash, hay fever _____		
36. STI /STD _____		
37. hepatitis (type _____) _____		
38. HIV /AIDS _____		
39. tumor, abnormal growth _____		
40. radiation therapy_____		
41. chemotherapy, immunosuppressive _____		
42. emotional problems _____		
43. psychiatric treatment _____		
44. antidepressant medication _____		
45. alcohol / street drug use _____		
ARE YOU:		
46. presently being treated for any other illness _____		
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____		
48. taking medication _____		
49. taking dietary supplements _____		
50. often exhausted or fatigued _____		
51. experiencing frequent headaches _____		
52. a smoker, smoked previously or use smokeless tobacco _____		
53. considered a touchy person _____		
54. often unhappy or depressed _____		
55. FEMALE - taking birth control pills _____		
56. FEMALE - pregnant / breastfeeding _____		
57. MALE - prostate disorders _____		

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug / Purpose	Drug / Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature _____ Date _____

INSURANCE INFORMATION

PRIMARY

Name of Insured: _____ Birthdate of Insured: (Day)____(Month)____(Year)____

Relationship: _____ Insurance Company: _____

Group/Policy # _____ ID/Certificate # _____ Division # _____

SECONDARY

Name of Insured: _____ Birthdate of Insured: (Day)____(Month)____(Year)____

Relationship: _____ Insurance Company: _____

Group/Policy # _____ ID/Certificate # _____ Division # _____

BILLING

Cornerstone Dental offers the following payment options. Please choose which option you would like to participate in:

OPTION 1: This option requires you to pay in full the day of treatment. We accept Visa, MasterCard, Amex, Debit and Cash. Our dental administrative staff will assist you with preparing & submitting claims to your dental insurance for reimbursement.

OPTION 2: This option allows your insurance to be billed directly and any outstanding amounts not covered are the responsibility of the patient and will be collected the day of services rendered or upon receipt of a cheque from the insurance company. For this option, we do require a credit card on file. Please fill out the required information below.

I agree to the financial responsibility for the amounts outstanding, not covered by my dental insurance to be applied to the credit card below.

CREDIT CARD (Circle One) VISA / MASTER CARD/ AMERICAN EXPRESS

Credit Card Number: _____ Expiry Date: _____ Security Code: _____

Signature: _____ Date: _____