Medical and Dental History Form

We are delighted to welcome you to Cornerstone Dental of Mahwah! We appreciate your time for filling out these registration forms as completely as you can. We look forward to working with you in maintaining your dental health with exceptional care and service.

1. Your Story

Today's Date: _____

Name:_____ _____ _____ ___
Last Name *First Name* *Preferred Name* *Initial*

Gender: ☐Male ☐Female Family Status: ☐Single ☐ Married ☐Child ☐Other

Birthdate _____ SS#_____ Cell # _____ Text ok? ☐Yes ☐No

Employer: _____ Occupation:_____

Referred from? :_____ Email Address:_____

Home Address: _____
Address *City* *ST* *Zip Code*

Home Phone #:_____ Work Phone #:_____

Preferred method to contact: ☐Cell ☐ Work ☐ Home ☐ Email ☐ Text

Emergency Contact _____ _____ _____
Name *Phone Number* *Relationship*

2. Dental Insurance (if applicable)

Primary Coverage	Secondary Coverage (if applicable)
Subscriber Name:_____	Subscriber Name:_____
Employer:_____	Employer:_____
Ins Carrier:_____	Ins Carrier:_____
Group Name:_____	Group Name:_____
Group Number:_____	Group Number:_____
Subscriber ID:_____	Subscriber ID:_____

3. Medical History

Are you in good health? ☐Yes☐ No Any recent changes in your health? ☐Yes ☐No

What is the approximate date of your last medical exam? _____

If you are a woman and pregnant, please let us know your due date here. _____

If you have a preferred pharmacy, please specify here.

_____
Name City ST

Indicate which of the following you have had, or have at present

☐ A.I.D.S/H.I.V. Positive
☐ ADD/ADHD
☐ Anemia
☐ Arthritis/Rheumatism
☐ Artificial Heart Valve/Pacemaker
☐ Artificial Joints (hip, knees, etc.)
☐ Asthma
☐ Autism
☐ Bleeding Disorder
☐ Blood Transfusion
☐ Bruise Easily
☐ Chemotherapy
☐ Chest Pain
☐ Chronic Cough
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disease
☐ Contact Lenses
☐ Cortisone Treatments
☐ Diabetes
☐ Diet (special/restricted)
☐ Eczema
☐ Emphysema
☐ Epilepsy or Seizures
☐ Fainting/Dizzy Spells
☐ Glaucoma
☐ Hay Fever/Allergies/Hives
☐ Hearing Problem
☐ Heart (surgery, disease, attack)
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis (A/B/C)
☐ High/Low Blood Pressure
☐ High Cholesterol
☐ Kidney Trouble
☐ Latex Sensitivity
☐ Liver Disease/Yellow Jaundice
☐ Mitral Valve Prolapse
☐ Nervous/Anxiety
☐ Neurological Disorders
☐ Psychiatric/Psychological Care
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Sleep Apnea
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcer

If you have any disease not listed here, please explain. _____

Have you lost or gained more than 10 pounds in the last year? ☐Yes ☐No

Have you ever had any surgery, hospitalization or serious illness? If yes, please explain.
_____

Are you are taking any medications or pills? Please list names, dosages, and frequency.
_____
_____

Do you smoke? ☐Yes ☐No If yes, how frequently? _____

Do you have any allergic reactions to any medications? If yes, please specify. _____

Do you take pre-medication (antibiotic) prior to dental treatment? If yes, please explain.
_____

Have you ever taken bone loss prevention drugs like Fosamax, Actonel, Boniva, or similar drugs? ☐Yes ☐No

Have you ever taken prescription medications for weight loss, like Fen-Phen, Redux or similar drugs? ☐Yes ☐No

If you are parent/ guardian of a child, are your child's immunizations up to date? ☐Yes ☐No

Are you in primary care under a physician due to any condition? ☐Yes ☐No
Specify for what: _____

Physician's Name and Contact Information:_____

3. Dental History

Please describe the reason of today's dental practice visit. How can we help?
_____

Please indicate if you have experienced any of the following.

☐Bad Breath
☐Bleeding Gums
☐Clenching/ Grinding Teeth
☐Dislike the Shape of Teeth
☐Food gets Trapped in between Teeth
☐Jaw Pain/ Tired Jaw/ Popping
☐Limited Mouth Opening
☐Loose Teeth or Change in Bite
☐Neck Ache
☐Sensitivity to Cold or Hot
☐Sensitivity to Sweets
☐Want Whiter, Brighter Smile

The information I have provided is true to the best of my knowledge. I will inform the office in case of any changes of health status. I authorize the doctor to perform all necessary treatment mutually agreed. I understand that I am financially responsible for any balance of myself or my dependents, if any.

I, the patient with dental insurance (if applicable), understand that I am responsible for payment rendered and for paying any copayment and deductibles that insurance does not cover. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I also authorize Cornerstone Dental of Mahwah or insurance company to release any information required to process my claim.

_____ _____

Signature of patient, or parent / guardian Date

_____

(If applicable), Relationship to patient

Consent For Use and Disclosure Of PHI (HIPAA Consent)

Under the Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI) means such as,

Names, Contact Number, Email Address, Social Security Number, Health Insurance Beneficiary Number, and so on.

By signing this form, you will consent to our use and disclosure of your Protected Health Information to carry out treatment, payment activities, and healthcare operations.

For example, we may use or disclosure your PHI to a physician or other healthcare provider providing treatment to you. We may use and disclosure your PHI to obtain payment for services we provide for you. We may use and disclosure your PHI in connection with our healthcare operations, to operate our practice.

Additionally, we may use and disclose your PHI when we would be required by law, law enforcement, and public health activities, and so on. You may revoke this authorization in writing at any time, except to the extent your PHI has already been disclosed under this authorization.

I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and healthcare operations.

_____ _____

Signature of patient, or parent / guardian Date