

## 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

Subscriber Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins Carrier: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_

#### Secondary Coverage (if applicable)

Subscriber Name: \_\_\_\_\_

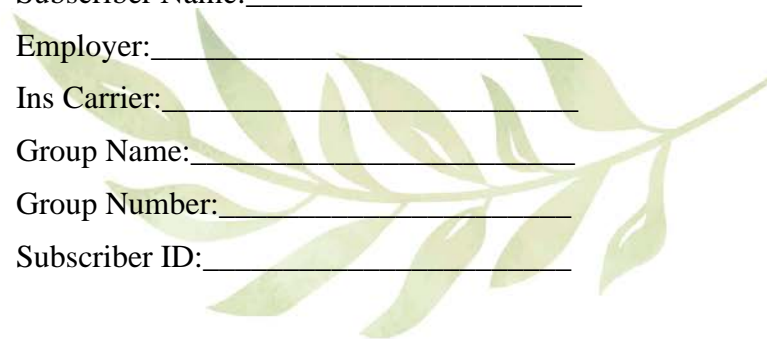
Employer: \_\_\_\_\_

Ins Carrier: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

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

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

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.

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

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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.

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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?

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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

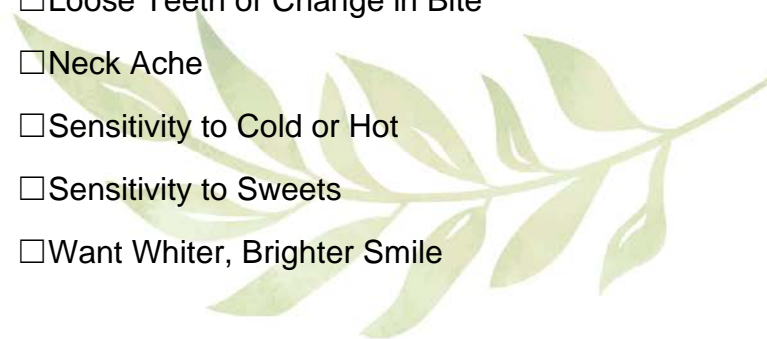
Loose Teeth or Change in Bite

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

