CORNERSTONE
FAMILY DENTISTRY

Patient Intake Form

Welcome to our practice! Please complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for you/your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

PERSONAL INFORMATION

Patient's Name: _____ □ Male □ Female

Date of Birth: _____ Drivers License #: _____ State: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Where do you prefer to receive calls? □ Home □ Work □ Cell Email address: _____

When is the best time to reach you? Days _____ Time: _____

Employer: _____ Occupation: _____

Referred by: _____

In the event of an emergency, who do you want us to contact?

Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY (Fill out only if different than patient)

Name of person responsible for scheduling and billing: _____ Relationship: _____

Date of Birth: _____ Drivers License #: _____ State: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Name of insured: _____ Relationship to patient: _____

Date of Birth: _____ Social Security No.: _____

Name of Employer: _____ Employer Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Member ID: _____ Group #: _____

Ins. Co. Mailing Address: _____ Ins. Co. Phone #: _____

DENTAL HISTORY

(Previous) Dentist: _____ City: _____ Office Phone #: _____

Date of Last Exam: _____ Last Cleaning: _____ Last X-rays: _____

Please check all that apply:

Had previous orthodontic care: □Yes □No When: _____ Name of Orthodontist: _____

Pain with the teeth, mouth, or jaws: □Yes □No Speech Problems: □Yes □No

Suffered any injuries to teeth or jaw: □Yes □No
Play a musical instrument that touches lips: □Yes □No
Suck thumb, fingers or pacifier: □Yes □No
Have any other habits or concern: □Yes □No
Breathe mostly through the mouth: □Yes □No
Have a parent who had braces: □Yes □No
Have habits that cause orthodontic problems: □Yes □No

Please describe _____

Has patient ever had complications following dental treatment? □ Yes □ No If Yes, please describe:_____

_____

Does patient have to be pre-medicated with an antibiotic prior to receiving dental care? □ Yes □ No

MEDICAL HISTORY

Physician's Name:_____City:_____Date of last physical:_____

Office Phone #:_____Pharmacy:_____Phone #:_____

Please check YES or NO to indicate if patient has, has had, or has been diagnosed with any of the following:

AIDS/HIV	□Yes	□No	Hepatitis (Type: A, B, C)	□Yes	□No	Prone to ear infections	□Yes	□No
Anemia	□Yes	□No	Hernia Repair	□Yes	□No	Prone to sore throats	□Yes	□No
Asthma	□Yes	□No	Kidney Disorder	□Yes	□No	Psychiatric Care	□Yes	□No
Bone Disorder	□Yes	□No	Latex Allergy	□Yes	□No	Rheumatic Fever	□Yes	□No
Diabetes (Type: 1, 2)	□Yes	□No	Latex Sensitive	□Yes	□No	Seizures	□Yes	□No
Dizziness or Fainting	□Yes	□No	Liver Disorder	□Yes	□No	Sinus Trouble	□Yes	□No
Endocrine	□Yes	□No	Mitral Valve Prolapse	□Yes	□No	Tonsils and/or adenoids removed	□Yes	□No
Facial/Jaw/TMJ Pain	□Yes	□No	Hearing Impaired	□Yes	□No	Trauma to face or jaw	□Yes	□No
Nervous Disorders	□Yes	□No	Tuberculosis	□Yes	□No	Heart Condition	□Yes	□No
Prolonged Bleeding	□Yes	□No	Ulcer	□Yes	□No	Heart Murmur	□Yes	□No
Prone to colds	□Yes	□No	Vision Impaired	□Yes	□No	Cold Sores/Fever Blisters	□Yes	□No

Other medical condition not listed above: _____

Medications:_____

Allergies: _____

Has patient ever been hospitalized? □YES □NO If YES, please describe: _____

FEMALE PATIENTS

Is patient pregnant □YES □NO If YES, what is the due date: _____ Is patient nursing? □YES □NO

Family, Guardian and/or authorized person(s) who may have access to your personal health information (PHI) or Cornerstone Family Dentistry staff can speak with regarding your care.

Name	Relationship	Phone #

ACKNOWLEDGEMENT: As a courtesy to our patients, we utilize an automated system to send reminders about your appointment via text or telephone call. Text message rates may apply from your mobile carrier, subject to the terms and conditions of your mobile carrier. Please notify us if you do not want to receive text messages.

Print Name:_____**Relationship to Patient:**_____

Signature:_____**Date:**_____

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Cancellation Policy for Dental Appointment

Our goal at Cornerstone Family Dentistry is to provide quality care in a timely manner. We do understand that emergencies occur and we ask our patients to give us a 24 hour notice whenever possible if they cannot keep an appointment. We appreciate your understanding and consideration regarding our cancellation and failed appointment policy.

- Cancellation or rescheduling of an appointment with 24 hours or more notification will result in no charge
- A failed appointment is an appointment that is cancelled/rescheduled without 24 hour notice or an appointment where a patient does not show up.
- Any failed appointment will be charged a fee of $50.
- After two (2) failed appointment you risk being dismissed from the practice.

To cancel appointments please call 919-595-1010. If you do not reach the front desk, you may leave a detailed message on the voicemail. You may also cancel your appointment using the confirmation text that is sent to you from Cornerstone Family Dentistry through our patient communication system.

_____	_____	_____
Print Patient Name	Patient/Guardian Signature	Date

CORNERSTONE
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Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____