CORNELL FAMILY DENTAL

PATIENT INFORMATIONN

Name: _____
Last Name *First Name* *Middle Initial*

Date of Birth _____ SSN _____ Sex ☐ M ☐ F ☐ O

Address _____ City _____ State _____ Zip _____

Cell Phone_____ Home Phone_____ Email_____

Emergency Contact Name _____ Phone Number _____ Relation _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Preferred Pronouns:

_____

Employer _____ Referred By _____

PRIMARY INSURANCE

Subscriber Name: _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate _____ SSN _____

Employer of Subscriber _____

Insurance Company _____

Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Subscriber Name: _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate _____ SSN _____

Employer of Subscriber _____

Insurance Company _____

Group # _____ Subscriber # _____

Name of other dependents under this plan _____

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DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? ☐ Y ☐ N

Former Dentist _____ City/State _____

Phone Number _____ Date of last dental care _____ Date of last x-rays if known _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping gums
- ☐ Periodontal treatment
- ☐ Food collection between teeth
- ☐ Grinding or clenching
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Dry Mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's Name _____ Phone_____ Date of last visit _____

Have you had any serious illness or operations? ☐ Y ☐ N If yes, describe _____

Are you currently under physician care? ☐ Y ☐ N If yes, describe _____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____

Women: Are you Pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Drug allergies? If yes, list all: _____

Have you ever taken any Osteoporosis medications? ☐ Y ☐ N Which and When?

_____

Check (✓) if you have had any of the following:

- ☐ Allergies (Food)
- ☐ Allergies (Material – i.e. latex, wool, metal, chemicals)
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes (Type I or II)
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Hemophilia/Abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS Positive
- ☐ Jaw pain
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Mitral valve prolapses
- ☐ Nervous problems
- ☐ Osteoporosis
- ☐ Pacemaker/ heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight loss/gain
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Sleep Apnea/ CPAP machine
- ☐ Spina bifida
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet/ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

Please list all the current medications you are taking:

_____

_____

Please list all the Vitamins and Supplements you are currently taking:

_____

Do you use Cannabis recreationally and/or medically? ⬜ Y ⬜ N

If yes, how often?

_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.