PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	AGE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE/TEXT	SS#
DATE OF BIRTH	SEX (CIRCLE) M F	MARITAL STATUS	SPOUSE'S NAME
PATIENT'S OCCUPATION	PATIENT'S EMPLOYER		
YOUR E-MAIL	EMERGENCY CONTACT AND PHONE NUMBER		

MAY WE CONTACT YOU BY: PHONE: Y/N TEXT: Y/N EMAIL: Y/N

How did you find out about our office? _____

DENTAL INSURANCE

Do you have dental insurance? YES NO If so, with which company? _____

SUBSCRIBER INFORMATION (If different from patient)

LAST NAME	FIRST NAME	MIDDLE INITIAL	SS#
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	DOB

CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct Dr. Jeremy Bewley and/or dental auxiliaries of his choice to perform dental treatment or oral surgery, including the use of any necessary or advisable local anesthesia, radiographs, or diagnostic aids, just as intra-oral photography.

1. I understand there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the risks/treatment, and that I fully understand the same.
2. I will be advised that the success of the dental treatment to be provided will require that the patient follows post operative and post care instructions of the dentist. I agree that the success of the treatment requires that all instructions be followed, and that regular office visits as directed, must be maintained.
3. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary to my oral health and well being, in the professional judgement of the dentist.
4. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling/numbing of the lips, gums, face, and tongue, allergic reaction, hematoma, fainting, and/or lips/cheek biting. I also understand that there are rare potential risks, such as unfavorable reactions to medications resulting in respiratory and cardiovascular collapse and lack of oxygen that could result in a coma or death. I understand and have been informed of the above risks and complications.
5. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen anagelsia depending on the judgement of the dentist. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I understand and have been informed of the above risks and complications.
6. I also authorize Dr. Bewley to use photographs, radiographs, and other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publication.
7. I hereby state that I have read and understand this consent and that all questions regarding treatment/procedures will be answered in a satisfactory manner. I understand that I have the right to be provided answers to my questions, which may arise during and after my treatment. I understand that this consent will remain in effect until such time that I choose to terminate it.

SIGNATURE OF PATIENT / GUARDIAN	DATE

HEALTH HISTORY

cornerstone DENTAL

Reason for today's visit: _____

Please list any specific complaints and problems you are currently having:

_____

_____

DENTAL HISTORY

1. Are you having any discomfort at this time? Y ☐ N ☐
2. If yes, explain: _____
3. Have you ever had any serious trouble associated with previous dental treatment? Y ☐ N ☐
4. If yes, explain: _____
5. Does dental treatment make you nervous? No___ Slightly___ Extremely___
6. Date of last dental visit: _____
7. How often do you brush your teeth: _____
   Toothbrush is : Soft ____ Medium ____ Hard ____
8. Do you have any of the following?

BLEEDING / SORE GUMS	Y	N	SENSITIVE TO HOT	Y	N
UNPLEASANT TASTE / BAD BREATH	Y	N	SENSITIVE TO COLD	Y	N
BURNING TONGUE / LIPS	Y	N	SENSITIVE TO SWEETS	Y	N
FREQUENT BLISTERS LIP/MOUTH	Y	N	SENSITIVE TO BITING	Y	N
SWELLING / LUMPS IN MOUTH	Y	N	FOOD GETS CAUGHT BETWEEN TEETH	Y	N
CHEEK / LIP BITING	Y	N	CLENCHING OR GRINDING OF TEETH	Y	N
CLICKING OR POPPING OF JAW	Y	N	LOOSE TEETH	Y	N
DIFFICULTY OPENING CLOSING JAW	Y	N	BROKEN OR MISSING FILLINGS	Y	N

MEDICAL HISTORY

1. My last physical examination was on: _____
   Physician's name: _____ Phone number : _____
2. Have you had any serious illness within the past 5 years? Y ☐ N ☐
3. If yes, explain: _____
4. Have you had any operations or have you been hospitalized within the past 5 years? Y ☐ N ☐ If yes, explain: _____
5. Do you use tobacco products? Y ☐ N ☐ If so, how much /often? _____
6. Do you use alcoholic products? Y ☐ N ☐ If so, how much /often? _____

7. Do you use caffeinated products? (Coffee, Tea, Chocolate) Y ☐ N ☐
   If yes, how much/often? _____
8. Has a Physician ever told you that you need to pre-medicate with antibiotics before having dental treatment? Y ☐ N ☐
9. Have you had Chemotherapy or Radiation treatment? Y ☐ N ☐
10. Did you ever take Aredia, Zometa, Actonel, Fosamax or Boniva? Y ☐ N ☐
11. Do you have or have you ever had any of the following? (circle yes or no)

RHEUMATIC FEVER	Y	N	DIABETES	Y	N
MITRAL VALVE PROLAPSE	Y	N	LIVER DISEASE / JAUNDICE	Y	N
HEART TROUBLE	Y	N	HEPATITIS A B C (CIRCLE)	Y	N
HIV/ AIDS (CIRCLE)	Y	N	HEART ATTACK	Y	N
ARTHRITIS	Y	N	HIGH BLOOD PRESSURE	Y	N
ARTIFICIAL JOINTS	Y	N	HEADACHES	Y	N
LOW BLOOD PRESSURE	Y	N	ULCERS	Y	N
STROKE	Y	N	STOMACH DISORDERS	Y	N
PACEMAKER	Y	N	KIDNEY PROBLEMS	Y	N
SINUS TROUBLE	Y	N	TUBERCULOSIS	Y	N
ASTHMA	Y	N	PERSISTENT COUGH	Y	N
HIVES	Y	N	COUGH UP BLOOD	Y	N
FAINTING SPELLS	Y	N	ANEMIA	Y	N
SEIZURES	Y	N	CONGENITAL HEART DISEASE	Y	N

If yes to any of the above, please explain:

_____

_____

12. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Y ☐ N ☐
13. Do you bruise easily? Y ☐ N ☐
14. Have you ever required a blood transfusion? Y ☐ N ☐
    If yes, explain circumstances and when:

    _____
15. Is there anything you want to discuss with your dentist in a private atmosphere? Y ☐ N ☐
16. Please list the name and dosage of all medications (Prescription or over the counter) you are currently taking, as well as the condition for which you are being treated.

MEDICATION	DOSAGE	CONDITION TREATED

17. Do you have any of the following allergies? (circle)

ASPIRIN	Y	N	LOCAL ANESTHETIC	Y	N
BARBITURATES, SEDATIVES	Y	N	SLEEPING PILLS	Y	N
PENICILLIN	Y	N	OTHER ANTIBIOTICS	Y	N
CODEINE	Y	N	OTHER NARCOTICS	Y	N
IODINE	Y	N	SULFA DRUGS	Y	N
LATEX	Y	N	NO KNOWN ALLERGY	Y	N

18. Do you have any other allergy not listed? _____
19. Do you have any other problem or condition not listed above that you think we should know about? _____
20. Are you pregnant? Y ☐ N ☐ If yes, due date: _____
21. Are you taking birth control or hormone therapy? Y ☐ N ☐
22. Do you use recreational drugs like Marijuana or Cocaine/ Crack? Y ☐ N ☐
23. Did a general dentist refer you to us for specialized treatment? Y ☐ N ☐
    If yes, please give us the name and phone number of the referring dentist:
    _____
    If not, please give us the name and phone number of your previous dentist:
    _____

24. List the names of any other specialist you have seen for dental treatment (Oral Surgeon, Endodontist, Periodontist, Orthodontist, etc…)

NAME OF SPECIALIST	TREATMENT RECEIVED

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in medication, I will inform the dentist at the next appointment.

SIGNATURE OF PATIENT / GUARDIAN	DATE
SIGNATURE OF STAFF MEMBER	DATE

CONSENT FOR CBCT SCAN

1. A CBCT scan, also known as Cone Beam Computerized Tomography, is an x-ray technique that produces a 3D image of your skull, allowing visualization of internal, bony structures in cross section, rather than as overlapping images, normally produced in conventional x-rays. CBCT scans are primarily used to visualize bony structures, such as teeth and jaws, not soft tissue structures, such as your tongue or gums.
2. Advantages of a CBCT scan over conventional x-rays: A conventional x-ray of your mouth limited your dentist to 2D visualization. Diagnosis and treatment planning can require a more complete understanding of a complex, 3D anatomy. CBCT examinations provide a wealth of 3D information which may be used when planning for dental implants, surgical extractions, maxillofacial surgery, and advanced dental restorative procedures, and evaluation of the paranasal sinuses. Benefits of CBCT scans include: higher accuracy when planning implant placement surgery, greater chance for diagnosing conditions such as vertical root fractures that can be missed on conventional x-ray films, greater chance of providing images and information which could result in the patient avoiding unnecessary dental treatment, better diagnosis of third molar (wisdom teeth) positioning, in proximity to vital structures, such as nerves and blood vessels prior to removal, and lastly enhanced ability for the dentist to see what needs to be done *before* treatment is started.
3. Radiation: CBCT scans, like conventional x-rays, expose you to radiation. In the office of Dr. Jeremy Bewley, the dose of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is approximate to ionizing radiation received on a flight from the USA to Australia.
4. Pregnancy: Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell the dentist if you are pregnant or planning to become pregnant.
5. Diagnosis of non-dental conditions: While parts of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist may not be qualified to diagnose conditions that may be present in those areas. If abnormalities, asymmetries, or common pathologic conditions are noted upon the CBCT scan, it may become necessary to send the scan to an Oral and Maxillofacial Radiologist for further diagnosis. However, by signing this form, you are acknowledging that your dentist may not be qualified to diagnose all conditions that may be present, and that his/her liability only extends to the limits of the dental purpose of the scan and its interpretation for that purpose. We are not responsible for interpretation or evaluation of the scan, but are only providing the scan for the evaluation at your dental office. Should referral to an Oral or Maxillofacial Radiologist or other qualified professional for review be necessary, you acknowledge that any costs associated with this separate review are your responsibility.

I, being, 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered and accept the risks of the CBCT scanning procedure, as described above. I therefore give my consent to have Dr. Bewley, and/or his staff, as he may designate, perform a CBCT scan.

SIGNATURE OF PATIENT / GUARDIAN	DATE
SIGNATURE OF STAFF MEMBER	DATE

Jeremy D. Bewley, DMD
10000 Brownsboro Rd. Suite #6
Louisville, KY 40241
Phone: 502-244-4474 Fax: 502-271-5490
cornerstonedentalky@gmail.com

RELEASE OF DENTAL RECORDS

To Whom It May Concern:

For the purpose of patient care, I give permission for my records to be released from the office listed below to Jeremy Bewley, DMD.

(Please provide former dentist's information below.)

_____

_____

_____

I understand that the specific type of information to be released includes a detailed report of examinations, treatment provided, x-rays, photographs, and any other dental records that pertain to me.

This consent is effective until I give notice otherwise to Cornerstone Dental.

When possible, please e-mail records. If unable, then fax is okay. Thank you!

PATIENT NAME (PLEASE PRINT)	DOB
SIGNATURE OF PATIENT / GUARDIAN	DATE

FINANCIAL AGREEMENT

Thank you for choosing Cornerstone Dental for your dental health needs! Below you will find important financial information. If you have any questions, please do not hesitate to ask a member of our staff.

Payment is due at the time treatment is rendered. We accept Cash, Check, MasterCard, Visa, Discover, American Express, and CareCredit.

Dental Insurance – As a courtesy to you, we will complete your insurance form and submit it to the insurance company. **Your estimated co-payment (the amount not covered by your insurance) for treatment is due at the time treatment is provided.** If you fail to bring the required insurance information to your appointments, we may ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office.

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is downgraded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____ **(initial)**

Our office will provide the necessary documentation your insurance company requests to settle the claim. If your insurance company has not made payment within 45 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Monthly payment options – If you need to make long-term payments we can offer financing with CareCredit which offers up to 12 months financing. You must qualify for this option. Please do not hesitate to ask us about CareCredit. We can help you apply right here in the office today.

Statements – All patients with an outstanding balance will receive a statement each month. There is a charge of $5.00 for each statement mailed after 60 days. All accounts over 90 days will be subject to our collection agency. Returned Checks – A fee of $25.00 will be charged for any returned checks. Broken Appointments – Our practice may charge you $25.00 for appointments broken without proper 24 hour weekday notice. We understand that emergencies occur. However, we want to make the appointment available for other patients. _____ **(initial)**

I assign directly to Cornerstone Dental all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice may use my heath care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent, I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Cornerstone Dental to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

SIGNATURE OF PATIENT / GUARDIAN	**DATE**
SIGNATURE OF STAFF MEMBER	**DATE**