CornerStone
FAMILY DENTISTRY

3102 N Main Street, Suite 102 · Hope Mills, NC 28348
P 910.423.2030 F 910.423.2060
www.cornerstonedentistryhopemills.com

Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____E-Mail: _____

Phone (Home): _____ Mobil/Cell: _____ (Work): _____ Ext: _____

In case of Emergency, contact: Name _____ Phone _____ Relation _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last x-rays: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chest Pain
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Defect
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse (MVP)
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due: _____
☐ Prescribed Weight Loss Med
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tobacco Usage
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Antibiotics Allergy
☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
☐ Other Anesthetic Allergy

OTHER:
☐ _____
☐ _____
☐ _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking any medications? Please List: _____

_____

What is your primary source of water? ☐ Well ☐ County
Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____