

Art A. Salinas, D.D.S.
Stacy R. Beltran, D.D.S., M.S.



Cornerstone Office

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RGV Endodontics

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Harrison, TX 78550

Phone: (956) 412-9500
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Patient Registration

Welcome to our office, please read and fill out carefully. We are happy to answer any questions you may have.

Name: _____
Last First Mi Preferred Name

Gender: Male Female **Marital Status:** (circle one) Married Single Child Other

Home #: _____ **Cell #:** _____ **SS #:** _____ **DOB:** _____

Address: _____ **City, State, Zip Code:** _____

Email Address: _____ **Name of Employer:** _____

In an emergency who should be notified? Please list Name and Phone number: _____

Whom may we thank for referring you? Dr. _____ Google Newspaper Word of mouth

Dental Insurance: Yes ___ No ___ (circle one) Aetna Ameritas BCBS Delta Dental Guardian Humana MetLife Other: _____

Primary Dental Insurance:

Insurance Plan Name: _____

Insurance Provider Phone #: () _____

Name of Insured: _____

Insured's DOB: / / SS #: - - -

Insured's Employer Name: _____

Patient's Relationship to Insured: Self Spouse Child Other

Secondary Dental Insurance:

Insurance Plan Name: _____

Insurance Provider Phone #: () _____

Name of Insured: _____

Insured's Birth Date: / / SS # - - -

Insured's Employer Name: _____

Patient's relationship to Insured: Self Spouse Child Other

General health: Excellent _____ Good _____ Fair _____ Poor _____

Name of Physician: _____ **Date of last physical examination:** _____

Any major change in health during the past year? Yes No

Check if you are allergic to: Aspirin Penicillin Codeine Latex Local anesthetic Other

Allergies to any other medications, not listed above? _____

Please list below any medications you are presently taking: (Name, for what condition?)

Office Use Only:

BP: _____

P: _____

Medical History: Please make a check mark whether you now or have ever been treated for:

<input type="checkbox"/> Pre-Med – Amoxicillin	<input type="checkbox"/> Pre-Med - Clindamycin	<input type="checkbox"/> Pre-Med - Other	<input type="checkbox"/> Allergies
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Bisphosphonates	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diabetes Last A1C: Date:
<input type="checkbox"/> Alzheimer’s Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> TMJ	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Stroke	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Other	

Do you have any other medical problem(s) not listed above? Yes No If yes, please list: _____

AN X-RAY(S) MAY BE NECESSARY TODAY, TO ESTABLISH A COMPLETE DIAGNOSIS.

Women Only: Pregnant Yes No **If yes, Due Date:** _____

When did you have your last cleaning appointment? _____

Do you smoke? Yes No If yes, how often? _____

How often do you see your dentist? 3 mo. 4 mo. 6 mo. 12 mo. Not Routinely

How often do you brush your teeth? Once a day Twice a day Every other day Not Routinely

How often do you floss? _____

Is your toothbrush () Soft () Medium () Hard? Do you use a () regular toothbrush or an () electronic toothbrush?

What else do you use to clean your teeth? () toothpick () floss () waterpic, () other _____

Consent Form:

I have reviewed the health history and believe it to be correct. If there is a change in health or medications taken, I will inform the doctor at my next appointment. I consent to treatment by the health care providers of this dental practice.

Patient Name (Please Print): _____

Date: _____

Patient/Guardian Signature: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I was given the opportunity to read the Privacy Notice and object to disclosures of my protected health information.

I agree that I am financially responsible for all changes whether paid by insurance or not.

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

I authorize the dentist to release all information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I permit a copy of the authorization to be used in place of the original.

HIPAA requires a dental practice to make a good faith effort to obtain a signed acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

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ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES

("Acknowledgement")

I acknowledge that I have received a copy of Cornerstone Periodontics HIPAA Notice of Privacy Practices.

Patient Name (Please Print)

Patient/Guardian Signature

Date