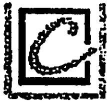

Crandall Dental Doug Cornish, D.M.D.

PATIENT INFORMATION

Name (First, MI, Last)	Nickname/Preferred Name
Address	
City	State	Zip

Email Address

Home Phone	Cell Phone

Patient's Sex: (circle one) Male Female	Marital Status: (circle one) Single / Married / Divorced / Widowed	Date of Birth	Age

Social Security #	Driver's License #

Occupation	Employer	Work Phone

Other family members seen in our office:	Whom may we thank for referring you to our office?

IN CASE OF EMERGENCY

Name	Relationship to patient	Daytime Phone

ACCOUNT INFORMATION

Are you going to be the person responsible for the account? *If no, please fill out the information below:* Y N

Name	Date of Birth	Phone

Address	City	State	Zip

Is this person a patient in our office? Y N

INSURANCE INFORMATION

Dental Insurance? *If yes, please fill out the information below:* Y N

Primary Policy Holder NAME DOB

Insurance Company	Group # / SSN

Secondary Policy Holder NAME DOB

Insurance Company	Group # / SSN

I request and authorize Dr. Doug Cornish to examine and provide dental treatment to me. This includes the taking of dental radiographs as deemed necessary by Dr. Doug Cornish to diagnose and/or treat my dental problem. I authorize the release of information regarding the diagnosis and treatment of my dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Patient Signature______________________________ Date______________

DENTAL AND MEDICAL HISTORY

Name		Date	

DENTAL HISTORY

What would you like for us to do for you today?

Are you in dental discomfort today?

Former Dentist: Phone:

Date of Last Dental Care: Date of Last X-rays:

How often do you brush? How often do you floss?

How do you feel abut the appearance of your teeth?

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

MEDICAL HISTORY

Physician's name: Phone:

Date of last visit:

Have you had any serious illnesses or operations? If yes, please describe:

Are you under physician care? If yes, please describe:

Have you had a blood transfusion? If yes, approximate dates:

Have you ever taken Fen-Phen/Redux?

WOMEN: Pregnant? Nursing? Taking birth control pills?

PLEASE PLACE A CHECK FOR ALL THAT APPLY TO YOU:

☐ AIDS/HIV Positive	☐ Epilepsy	☐ Psychiatric care
☐ Anaphylaxis	☐ Fainting	☐ Rapid weight gain or loss
☐ Anemia	☐ Food allergies	☐ Radiation treatment
☐ Arthritis, Rheumatism	☐ Glaucoma	☐ Respiratory disease
☐ Artificial heart valves	☐ Headaches	☐ Rheumatic/Scarlet fever
☐ Artificial joints	☐ Heart murmur	☐ Shingles
☐ Asthma	☐ Heart problems (describe:)	☐ Shortness of breath
☐ Atopic (allergy prone)	☐ Hemophilia/Abnormal bleeding	☐ Skin rash
☐ Back problems	☐ Herpes	☐ Spina Bifida
☐ Blood disease	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High blood pressure	☐ Surgical implant
☐ Chemical dependency	☐ Jaw Pain	☐ Swelling of feet or ankles
☐ Chemotherapy	☐ Kidney disease or malfunction	☐ Thyroid disease or malfunction
☐ Circulatory problems	☐ Liver disease	☐ Tobacco habit
☐ Cortisone treatments	☐ Material allergies(latex, wool, metal, chemicals)	☐ Tonsillitis
☐ Cough, persistent	☐ Mitral valve prolapse	☐ Tuberculosis
☐ Cough up blood	☐ Nervous problems	☐ Ulcer/Colitis
☐ Diabetes	☐ Pacemaker/Heart surgery	☐ Venereal disease

Is patient currently taking any medications? If yes, list all:	Does patient have drug allergies? If yes, list all:

AUTHORIZATION

I have reviewed the information 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.

Signature: Date:

Crandall Dental

Doug Cornish, DMD / 1101 E. Highway 175 Ste 700 / Crandall TX, 75114 / (972) 427-0333

Written Financial Policy

Thank you for choosing Crandall Dental. Our primary mission is to deliver the best and most comprehensive dental care possible. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

-Cash, Check, Visa, Mastercard, American Express or Discover

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash, check or debit card prior to completion of care for treatment plans of $300 or more.

-NO INTEREST Payment Plans from CareCredit

Allows you to pay over time with NO INTEREST
Convenient, low monthly payment plans available
*No annual fees or pre-payment penalties

Please Note:

Crandall Dental requires payment at the time of your appointment. We also require ½ of your estimated portion or treatment total at least 2 weeks prior to your appointment for treatment plans over $2000.

We accept payment in thirds for treatments over $1000.

We also offer 12 months no interest in-house financing for orthodontic treatment over $2800 after a $300 down payment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $35 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Doug Cornish, DMD charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Signature____Date:______________

Please Print Name:____

*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
*Subject to credit approval.
*However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Crandall Dental

Doug Cornish, D.M.D
1101 E. Hwy 175, Suite 700
Crandall, TX 75114
972.427.0333 972.472.3908 (fax)

HIPPA Authorization Form

I authorize the following individuals (ex: spouse, parent/guardian, sibling) to have access to and be informed of this patient's dental/ medical information and care.

Name: ______________________________

Relationship: ____________________

I authorize information about my health, appointments, treatment and billing to be conveyed via:

- o Cell Confirmation
- o Home Phone
- o Work Phone
- o Any of the above
- o Text messages
- o Email

Signature of Patient: ______________________________

Print Name: ______________________________

Date: ____________________