

Brent Cornelius, D. D. S.



PATIENT INFORMATION

Full Name
I prefer to be called
Address
City
State
Zip
Marital Status: Single Married Divorced Widow(er)
Sex: Male Female
Patient SS#
Occupation
Employer
Spouse/Parent Name
Spouse/Parent DOB
Spouse/Parent SS#
Spouse/Parent Occupation
Spouse/Parent Employer
Whom may we thank for referring you?

ACCOUNT INFORMATION

Who is responsible for this account?
Relationship to patient
Insurance Company
Group #
Subscriber's name
DOB
SS#
Relationship to patient

I understand that I am responsible for all charges, regardless of insurance coverage or lack thereof. If insured, I hereby authorize the release all information necessary to secure payment of insurance benefits and assign payment of those benefits directly to Dr. Brent Cornelius. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

CONTACT INFORMATION

Mobile #
Work #
Home #
Email address
Spouse's work #
Best time and place to reach you

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name
Relationship
Mobile #
Home#
Work #

DENTAL HISTORY

Reason for today's visit
Reason for leaving last dentist
What did you like most about your last dentist?
Least?
How long since your last dental visit?
Last cleaning?
Last full mouth x-rays?
How often do you brush?
Floss?
Other aids (i.e. rinses, picks)?
Former dentist
City
State
Do you like sedation and/or laughing gas during dental visits?
Do you like your teeth's appearance?
Would you make any changes to your teeth (i.e. color, gaps, shape)?
Have you ever had an upsetting dental experience?
Do you have any special concerns about your visit? Nervous Time Cost Other
Anything else you would like us to know?

DENTAL HISTORY (CONTINUED)

Please mark "Yes" or "No" to indicate if you have, or have ever had, any of the following:

- | | | | |
|-------------------------------|--|------------------------|--|
| Bleeding Gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to Sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking/Popping Jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to Biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Locked Open or Closed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to Cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food Collection Between Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to Hot | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding/Clenching | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain Around Ear | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wear a Night Guard | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gum Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gums Swollen/Tender | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores/Growths in Mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Pain/Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken Teeth/Fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loose Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry Mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICAL HISTORY

Physician's Name _____ Phone # _____ How long since last visit? _____

Please mark "Yes" or "No" to indicate if you have, or have ever had, any of the following:

- | | | | | | |
|------------------------|--|---------------------|--|---------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reflux/GERD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Require Pre-Med | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or Growth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you drink alcohol? _____ How often? _____
 Do you use tobacco? _____ How much per day? _____ Do you want to quit? _____
 Type of tobacco: Cigarettes Cigars Pipe Smokeless

WOMEN: Are you pregnant? _____ How far along? _____ Nursing? _____

MEDICATIONS

Please list medications you are taking (prescription & over-the-counter) _____

Have you ever taken medication for osteoporosis? _____
 Pharmacy Name _____
 Pharmacy Phone # _____

ALLERGIES

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |
| | _____ |
| | _____ |
| | _____ |
| <input type="checkbox"/> None | |

The information I have provided on this form is complete, truthful and accurate. I understand that withholding pertinent information may prevent proper and/or optimal treatment.

Patient/Parent Signature _____ Date _____

Brent Cornelius, DDS _____

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Payment Options:

- Payment is due the day of service unless financial arrangements have been made prior to the appointment. All charges are the responsibility of the patient, regardless of insurance coverage or lack thereof. We accept cash, check, Visa, MasterCard, American Express, and Discover.
- We offer a 5% discount to those who pre-pay for their appointment 48 hours in advance.
- For those interested in extending payment over a longer period of time, ask us about interest free financing through CareCredit.

For those with dental insurance:

- Our office understands the value of insurance benefits and we gladly accept assignment of benefits as a courtesy to our patients.
- Rarely does an insurance company cover an entire bill. We will do our best to estimate your deductible and the portion that your insurance company will cover. However, any remaining balance is your direct responsibility. This includes any non-covered services, yearly deductible, or co-payments particular to your individual insurance plan.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will cover. Since it would be impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under the terms of your policy. Bring us a copy of your benefit booklet if you would like help interpreting your benefits.
- While we are happy to work with you to maximize your insurance benefits, please remember that your insurance contract is between you, your employer, and the insurance company. You are privy to much more information about your coverage than we are. We have no control or input regarding decisions made by your insurance company.
- If you are covered by two insurance plans, we ask that you pay your portion of the primary claim. After your primary carrier pays, we will provide you with a claim to send the secondary carrier with payment assigned directly to you.
- Insurance claims unpaid after 60 days become the responsibility of the patient. After 60 days, we require that you pay the outstanding balance. We will provide any necessary documentation to help you collect payment from your insurance company.

Important Information:

- All cell phones and pagers must be turned off in the treatment area.
- Due to potentially dangerous chemicals and instruments, children are not allowed to accompany patients in the treatment area. We ask that you arrange childcare prior to your appointment time.
- If you are unable to honor your reserved appointment time, a minimum of 24 hours notice is required. A \$25 fee may be charged per half hour missed if 24 hours notice is not received.
- In order to stay on schedule, patients who arrive late for an appointment will have to be rescheduled.
- Returned checks are subject to a \$25 service fee.
- Balances older than 90 days may be subject to additional collection fees and 1.5% monthly interest.
- Any fees related to collection of a bill (i.e. attorney fees, court costs, and collection agency fees) will be added to outstanding accounts and become the patient's responsibility.

Minor Patients:

- Consent for treatment must be received from a parent or guardian for any patient under the age of 18.
- State law requires that a parent or guardian remain in the office while treatment is rendered to a minor.
- For patients whose parents are divorced, the parent or guardian who accompanies the child is responsible for payment on the day of service.

I have read and understand the above information. I understand that I am responsible for any fees incurred.

Printed Name

Signature

Date

Brent Cornelius, D. D. S.

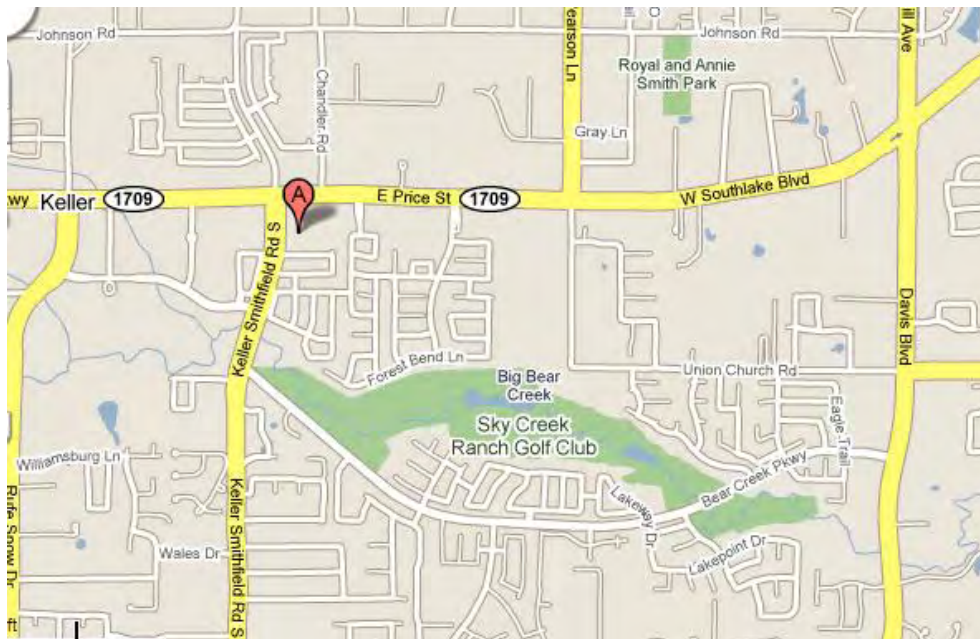
Directions To Our Office

We are located in the Keller Crossing Shopping Center at the southeast corner of Keller Parkway and Keller-Smithfield. We are near the Keller-Smithfield entrance between Mezza Luna and Whataburger.

Depending on where you are coming from, Keller Parkway is also known as FM 1709, Golden Triangle or Southlake Boulevard.

From Denton Hwy (377): Go east on Keller Parkway for approximately 2 miles. Turn right on Keller-Smithfield then take an immediate left into the Keller Crossing Shopping Center.

From Davis: Go west on Southlake Blvd. (FM 1709) for approximately 1.5 miles. We are 0.5 miles past Pearson. Turn left into the Keller Crossing Shopping Center just before reaching Keller-Smithfield.



**1540 Keller Parkway, Suite 140
Keller, TX 76248
817-431-4200**

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What You Should Know About Dental Insurance...

We do not have a contract or preferred provider agreement with any insurance company. This ensures that we are able to focus on what is best for you, not what is best for your insurance company. As a courtesy to our patients, we will file your claim and accept assignment of benefits. We are able to file on your behalf as long as your contract with your insurance company allows you to choose your own doctor.

We try to gather as much information regarding your policy as possible. However, we are only able to acquire the information that your insurance company is willing to provide over the phone. Insurance companies are not often forthcoming with this information. We update our records every time a claim is processed to try and provide the most accurate estimate possible. Your insurance company will not guarantee payment until they process your claim. By law, your insurance company has 30 days to process the claim. If payment is delayed or denied, we may require your assistance in resolving the matter.

Each insurance company has “Usual, Customary & Reasonable Allowances” (UCR), which are based on how much your employer pays for your dental coverage. The more your employer pays for the plan, the higher the “allowable UCR”.

Although insurance companies often say you will receive “two free cleanings” per year – they are never “Free”. They are 100% of the maximum allowed on your plan. The maximum allowed depends on how high your UCR is. They also deduct the amount of your cleaning from your calendar year maximum.

Each plan is different. It is impossible for us to keep track of all the specifications and exclusions of every dental plan. We encourage you to become familiar with your dental plan and its conditions. We are always available to answer any questions you might have.