Bell Family Dentistry

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We are pleased to welcome you to our practice, Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ E-mail: _____ Cell #: _____

Name _____ Soc. Sec. # _____

Address _____ Home #: _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____ Business #: _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency. Contact Name: _____ Phone _____

Person responsible for account _____

If student, what school _____

Primary Insurance

Insured Name _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Employer of Insured _____

Business Address _____ Business Phone _____

Insurance Company _____

Group # _____ Subscriber I.D. # _____

❑ Yes, I have a secondary carrier. Name _____

Dental History

Reason for Today's visit _____

Former dentist _____

Address _____ Phone _____

Date of last dental care _____ Date of last dental X-rays _____

Check ( ) if you have had any of the following:

- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ An upsetting dental experience
- ❑ Sensitivity to hot or cold
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth
- ❑ Serious injury to mouth or head
- ❑ Orthodontic treatment
- ❑ Oral Surgery
- ❑ Periodontal treatment
- ❑ Nitrous Oxide Analgesia

Please Complete Both Sides

NAME:

Medical Information

1. Are you under the care of a medical doctor? _____ If yes for what? _____

   Physician's Name _____ Phone number _____

   Address _____ City _____ State _____ Zip _____

2. Are you taking any medication or drugs? _____

   If yes please list below:

Drug	Purpose	Dosage	Taken Since	Prescribing Doctor

3. Are you aware of having an allergic (or adverse reaction) to any medication or substance? _____

   If yes please list: _____

4. Have you ever been advised to take any antibiotic before dental treatment? _____

   If yes please list: _____

5. Are you pregnant? _____ If yes what month? _____

6. Have you ever taken any bone strengthing drugs like Boniva or other Bisphosphonate ? _____

7. Indicate which of the following you have had or have at present.

Yes	No		Yes	No		Yes	No	
❑	❑	Heart (Surgery, Disease, Attack)	❑	❑	Stroke	❑	❑	Acid Reflux
❑	❑	Chest Pain	❑	❑	Swollen Ankles	❑	❑	Cancer
❑	❑	Angina Pectoris	❑	❑	Kidney Trouble	❑	❑	Radiation Therapy
❑	❑	Congenital Heart Disease	❑	❑	Ulcers	❑	❑	Tumors
❑	❑	Heart Murmur	❑	❑	Diabetes	❑	❑	Chemotherapy
❑	❑	Heart Pacemaker	❑	❑	Thyroid Problems	❑	❑	Hepatitis A (infectious) B (serum)
❑	❑	High Blood Pressure	❑	❑	Glaucoma	❑	❑	Venereal Disease
❑	❑	Arteriosclerosis	❑	❑	Neurological Disorders	❑	❑	A.I.D.S. or H.I.V. Positive
❑	❑	Mitral Valve Prolapse	❑	❑	Emphysema	❑	❑	Cold Sores / Fever Blisters
❑	❑	Artificial Heart Valve	❑	❑	Tuberculosis	❑	❑	Blood Transfusion / Hemophilia
❑	❑	Rheumatic Fever	❑	❑	Asthma	❑	❑	Anemia
❑	❑	Arthritis	❑	❑	Hay Fever	❑	❑	Sickle Cell Disease
❑	❑	Rheumatism	❑	❑	Allergies or Hives	❑	❑	Liver Disease
❑	❑	Cortisone Medicine	❑	❑	Sinus Trouble	❑	❑	Yellow Jaundice
❑	❑	Artificial Joints (hips, knee, etc.)	❑	❑	Allergy to Latex	❑	❑	Epilepsy or Seizures
❑	❑	Drug Addiction	❑	❑	Allergy to Metal (Jewelry, etc.)	❑	❑	Fainting or Dizzy Spells
						❑	❑	Nervousness

8. Do you have or have you had any disease, condition, or problem not listed? _____

   If yes, please list: _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I understand that a 1.5% finance charge (18% APR) may be added to my account.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ Date _____

(CIRCLE)