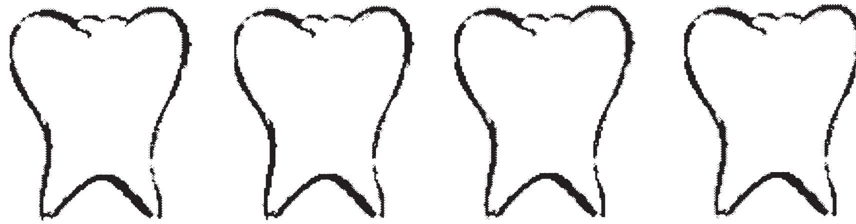
Welcome



Bell Dental Group is pleased to welcome you to our practice. Take a few minutes to fill out this form completely. If you have any questions we would be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _________Home Phone ( ) _____________Cell Phone ( ) _____________Work Phone ( ) ________
Name____ SS # ________________________________
First Name Middle Initial Last Name
Status: **Married** **Widowed** **Single** **Minor** **Separated** **Divorced**
Responsibly Party Name (if patient is a minor) ____
Address __________________________________City ______________ State _______ Zip Code __________
Please circle your preference of appointment confirmation: **E-mail** **Home phone** **Cell Phone** **Work Phone**
E-mail ____
Sex M F Age________ Birth Date ______________
Patient Employer ___________________________ Occupation ______________________________________
Employer Address _________________________________ Employer Phone ___________________________
Spouse's Name______________________________ Do you have Children? **Y N** How many_____________
In case of Emergency who should be notified? ____________________Phone ( ) ____________________
Medical Doctor's Name: ______________________________ M.D.'s Phone #: _____________________
Referral Source: ____

Dental Insurance

Primary Dental Insurance Policy:
Name of Insurance Company:
____
Insurance Company Claims Address:
____
Insurance Phone #:__________________________
Group #: ________________________________
Policyholder's Name: _______________________
Policyholder's Employer: ____________________
Policyholder's Employer Phone #______________
Policyholder's SS # / ID #: __________________
Policyholder's Birth Date: ___________________
Policyholder's Phone #:______________________
Relationship ______________________________

Secondary Dental Insurance Policy:
Name of Insurance Company:
____
Insurance Company Claims Address:
____
Insurance Phone #:______________________________
Group #: ____________________________________
Policyholder's Name: ___________________________
Policyholder's Employer: ________________________
Policyholder's Employer Phone #__________________
Policyholder's SS # / ID # ______________________
Policyholder's Birth Date: _______________________
Policyholder's Phone#:__________________________
Relationship __________________________________

Please Complete Both Sides

Dental History

Reason for today's visit: **Exam** **Emergency** **Consultation**
Are you in Pain: **Y** **N** How long? ________________________
List Dental concerns and discomforts: ____
Previous Dentist: ____________________________________ Phone: ( ) ______________________________
Last Dental Exam________/________/________ Last Dental X-ray's ____________/_________/___________
Times/day you brush? ____________________Times/week you floss?_________________________
What type of tooth brush bristles do you use? ______________________________
How do you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History

Do you require **PRE-MEDICATION**? Yes No Not Sure
Are you taking any of the following medications? **Nerve pills** **Pain killers (including Asprin)**
Muscle Relaxers **Stimulants** **Blood Thinners** **Tranquilizers** **Insulin**
Others please list: ____
Do you have or have you had any of the following diseases, medical conditions, or procedures?
Check ALL that apply:

- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling, Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsilltis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS
List medications you are currently taking:
____
____

ALLERGIES
List any allergies:
____
____

Acknowledgements/Authorizations

♦ I hereby acknowledge that I have received or have been given the opportunity to receive a copy of BELL DENTAL GROUP'S Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have received the opportunity to receive the Notice of our Privacy Practices.

♦ I acknowledge that I have received or have been given the opportunity to receive a copy of BELL DENTAL GROUP'S Financial Guidelines and by signing below I understand all information contained within the **Financial Guidelines**.

♦ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with a financial advisor. If account becomes delinquent within 90 days of the date of service and there are no financial arrangements made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

♦ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

♦ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ Date_____/_______/__________
Adult patient Parent/guardian Spouse