BELL
Family Dental

Patient Registration and Health History

Patient Information

Date: _____ SSN: _____

Patient Name: _____

Home Phone: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Sex: **Male** or **Female** Birthdate: _____

Employer: _____ Work Phone#: _____

Emergency Contact Name: _____

Emergency Contact Phone#: _____

Preferred Contact Phone#: _____

Physician's Name: _____

Last Visit to Physician: _____

How did you hear about our office?_____

Dental Insurance

Primary Dental Insurance: _____

Subscribers Name: _____

Birthdate: _____ SSN: _____

Relationship to Patient: _____

Secondary Insurance: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage as noted above, and assign directly to Dr Bell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions including appeals. The above named dentist may use my health care information and may disclose such information to the above names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient/Guardian Signature: _____

Date: _____

Dental Health History

Please complete to the best of your knowledge:	**Yes**	**No**
Do you use tobacco products?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you have difficulty chewing?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐

	Yes	**No**
Does your mouth feel dry often?	☐	☐
Have you noticed slow-healing sores in your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Hot foods or liquid?	☐	☐
Cold foods or liquid?	☐	☐
Sweets?	☐	☐
Biting?	☐	☐
Does your jaw make noise so that is bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do you have any headaches upon awakening in the morning?	☐	☐
Do you experience jaw or ear pain?	☐	☐

Medical Health History

Name:_____ Date:_____

Do you have, or have you had the following?	Yes	No
AIDS/HIV	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joints, Location_____	☐	☐
Asthma	☐	☐
Autism Spectrum	☐	☐
Back Problems	☐	☐
Bleeding Problems/Easy Bruising	☐	☐
Cancer, Type _____	☐	☐
Chemical/Alcohol Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Problems	☐	☐
Cortisone Treatments	☐	☐
Cough, persistent or bloody	☐	☐
Depression/Anxiety	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting/Dizziness	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Head Injury	☐	☐
Heart Murmur	☐	☐
Hepatitis, Type _____	☐	☐
Herpes or other STD	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Pace Maker	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Special Diet	☐	☐
Stroke	☐	☐
Swollen Feet or Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Weight loss, unexplained	☐	☐

_____
Other Condition or Disease not listed above

Women

Are you Pregnant?	☐	☐
Expected delivery date _____		
Taking contraceptives or other hormones?	☐	☐

Airway Heath

Do you feel excessively tired throughout the day?	☐	☐
Do you wish you slept better and had more energy?	☐	☐
Have you ever been told you occasionally snore?	☐	☐
Have you or a loved on been prescribed a C-PAP?	☐	☐

Allergies

Local Anesthetics (“Novocaine”)	☐	☐
Penicillin	☐	☐
Valium or other sleeping pills	☐	☐
Aspirin	☐	☐
Tylenol	☐	☐
Ibuprofen	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Metals	☐	☐
Sulfa	☐	☐

Other_____

Medications

List all medications you are currently taking

_____
_____
_____
_____
_____
_____

Staff use only:

Blood Pressure/Pulse-

Consent:

I hereby agree to allow Dr. Bell and associates to perform any necessary, agreed upon dental services. I also allow them to delegate to the auxiliaries of their choice as needed to accomplish my treatment. I understand that there is inherent risk with any dental procedure, including dental anesthesia. I hereby allow them to take any necessary x-rays, study models or photographs as needed for my dental care. **I understand that the entire fee is my responsibility and that Dr. Bell’s office will submit to my dental insurance as a courtesy. I agree to be responsible for any collection fees necessary to pursue a past debt.**

Patient/Guardian Signature _____ Dentist Signature _____