BELL DENTAL
COSMETIC & FAMILY

2680 E JOYCE BVLD | FAYETTEVILLE, AR 72703 | 479.521.0066

PATIENT INFORMATION

Patient's Full Name_____ Prefer to be Called_____

Names and Ages of Children _____

Patient's Address_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email _____Preferred method(s) of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Social Security #_____ Date of Birth_____ Marital Status: ❑ Married ❑ Single

Employer/School _____ Phone_____

Emergency Contact_____Relationship_____Phone_____

Whom May We Thank for Referring You?_____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name_____ Relationship to Patient_____

Address_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email _____Preferred method(s) of contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Social Security #_____ Date of Birth_____

Employer_____ Phone_____

INSURANCE

Dental Insurance Company _____Name of Subscriber_____ Date of Birth_____

Relationship to Patient _____ Group #_____Identification / SSN # _____

Secondary Dental Insurance_____ Name of Subscriber_____ Date of Birth_____

Relationship to Patient _____ Group #_____Identification / SSN # _____

RELEASE

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.
I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.
I consent to the release of credit reports and information regarding my credit history to the doctor(s).
I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or inter disciplinary team members in scientific presentations or scientific literature.

Date: _____ Patient or Guardians' Signature_____

MEDICAL AND DENTAL HISTORY

Patient's Full Name _____ ❑ Male ❑ Female

Date of Birth _____ Age_____ Weight_____ Height_____

Previous Dentist_____ Date of last dental cleaning? _____

Patient's Physician_____ Are you currently under Physician's Care? _____

Reason for Today's Visit _____ Are you happy with the appearance of your teeth? _____

If "No", Please Explain _____

Describe any injuries to your mouth, teeth, or jaw _____

List all current medications _____

List all drug allergies _____

MEDICAL HISTORY

Please check all that apply and describe further below, if necessary.

- ❑ Allergy to Latex or Metal(s)
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis or rheumatism
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Difficulty
- ❑ Bruise Easily
- ❑ Cancer (type, date)
- ❑ Chemotherapy
- ❑ Chest Pains or Heart Attack
- ❑ Cold Sores/Fever Blisters
- ❑ Connective Tissue Disease
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever/Allergies
- ❑ Heart Murmur
- ❑ Heart Trouble (murmur, mitral valve prolapse, etc.)
- ❑ Heart Pace Maker
- ❑ Hepatitis or Liver Disease
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV or AIDS Positive Test
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Kidney or Bladder Problems
- ❑ Leukemia
- ❑ Lung Disease (T.B., Emphysema, etc.)
- ❑ Mitral Valve Prolapse
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Pregnant or Possibly Pregnant
- ❑ Prosthetic Devices (heart valve, hip, etc.)
- ❑ Radiation Treatments
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Serious illnesses not listed (type, date)
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sinus Trouble
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Shortness of Breath or Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tumors or Growths
- ❑ Ulcers or Stomach Problem

DENTAL HISTORY

- ❑ Drink Coffee
- ❑ Use Tobacco (type, how much)
- ❑ Consume Alcoholic Beverages
- ❑ Pain, Popping, Catching or Locking Jaw Joints
- ❑ Clench your Teeth
- ❑ Wake up with Sore Jaws
- ❑ Frequent Headaches
- ❑ Dizziness, Ringing, or Pain in Ears
- ❑ Tenderness or Stiffness in Jaw, Neck, Back
- ❑ History of TMJ Problems or Treatment
- ❑ Treated for or told you have gum disease
- ❑ Treated or consulted of orthodontic tx.
- ❑ Had any Oral Surgery
- ❑ Dental X-Rays taken in the Last Year
- ❑ Excessive Fear of Dental Treatment
- ❑ Brush Your Teeth (How Often)
- ❑ Floss Your Teeth (How Often)
- ❑ Bad Breath or Unpleasant Taste in Mouth
- ❑ Bleeding Gums
- ❑ Sore Teeth
- ❑ Tooth Sensitivity (Hot, Cold, Sweets)
- ❑ Suck Your Thumb, Finger, Lip
- ❑ Tongue Thrust Habit
- ❑ Gag Easily
- ❑ High Priority on Keeping Natural Teeth

Please expand on the above information or add anything you feel is important. _____

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_____

The above information is accurate and complete to the best of my knowledge.

Date: _____ Patient or Guardians' Signature_____

Updated: _____Patient or Guardians' Signature_____

Updated: _____Patient or Guardians' Signature_____

Updated: _____Patient or Guardians' Signature_____