Registration

PATIENT INFORMATION

Name____ Date of Birth_____________________________________

Address:____ Home Phone:_____________________________________

City/Zip:____ Work Phone:_____________________________________

Email Address:_____________________________________ Social Security #:_________________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:_______________________ Birth Date___________ Home Phone:_____________________________________

Address:____ Work Phone:_____________________________________

City/Zip: ____ Social Security #:_________________________________

How Did You Hear About Bell Dental Center? ____

MEDICAL/DENTAL HISTORY

Are you in good health? ___________________ (Women) Are you pregnant?_________________________

Are you taking any medication?_____________ How many months?__________________________________

Type of medication:______________________ Physician:____

Please Mark Yes or No

Phen-Phen use __Y __N Anemia __Y__N Chemical Dependency __ Y__N Smoke __Y__N

Rheumatism __Y __N Glaucoma __Y__N Psychiatric __Y__N Heart Failure __Y__N

Hemophilia __Y __N Cortisone Medicine __Y__N Drug Addiction __Y__N High Blood Pressure __Y__N

Allergies __Y__N Thyroid Disease __Y__N Liver or kidney __Y__N Prosthetic Valves/joints __Y __N

Diabetes __ Y__N Epilepsy __Y__N Asthma __Y__N Rheumatic Fever __Y__N

Ulcers __Y__N AIDS/HIV __Y__N Venereal Disease __Y__N Malignancies __Y__N

Stroke __ Y__N Heart Murmur __Y__N Chemotherapy __Y __N Heart Surgery __Y__N

Heart Pacemaker __Y __N Heart Attack/Disease __Y __N Infectious Hepatitis __Y __N Tuberculosis __Y__N

Are you allergic or made sick by: Penicillin?___ Novocain?___Latex?___Other?_________________________________

Have you ever had trouble with prolonged bleeding after surgery?____

Are you concerned about the color of your teeth___Yes___No Date of your last dental exam?

Reviewed and signed by Dentist/Hygienist: _______________/_________________Date_____________

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In order to maintain our LOWCOST, we ask for payment at time of service. Any portion not covered by insurance is the patient's responsibility.

Registration

AUTHORIZATION

I hereby authorize the doctor/and or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

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Signature of Patient (or guardian)