# EDWARD BELL, DDS, PA

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(336) 983-2176

**PATIENT INFORMATION**
*(PLEASE PRINT)*

NAME _____ BIRTHDATE _____
*FIRST* *MI* *LAST*

ADDRESS _____

CITY _____ STATE_____ ZIP_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL _____ PARENT/GUARDIAN'S NAME _____

**CHECK ONE: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED**

**RESPONSIBLE PARTY**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

HOME PHONE _____ CELL PHONE _____

**DENTAL INSURANCE INFORMATION**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/ SIN _____ NAME OF EMPLOYER _____

NAME OF INSURANCE COMPANY _____ PHONE NUMBER OF INS COMPANY _____

**SECONDARY DENTAL INSURANCE ?**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/ SIN _____ NAME OF EMPLOYER _____

NAME OF INSURANCE COMPANY _____ PHONE NUMBER OF INS COMPANY _____

**ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES".

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

By signing this I hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date:_____

## PATIENT MEDICAL HISTORY

1. **Are you under medical treatment now** **Y N**
2. **Have you ever been hospitalized** **Y N**
3. **Are you taking any medications** **Y N**
4. **Do you use Tobacco** **Y N**
5. **Do you use Alcohol** **Y N**
6. **Do you use Cocaine or other Drugs** **Y N**
7. **Are you wearing contact lenses** **Y N**

**ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING:**

- ☐ **LATEX ALLERGY**
- ☐ **Local Anesthetics (ex. Novocaine)**
- ☐ **Penicillin**
- ☐ **Sedatives**
- ☐ **Iodine**
- ☐ **Other** _____

_____

## Women Only

1. Are you pregnant or think you may be pregnant? Y N
2. Are you nursing? Y N
3. Are you taking Birth Control Pills? Y N

## HAVE YOU EVER TAKEN:

- ☐ COUMADIN
- ☐ FOSAMAX
- ☐ ACTONEL
- ☐ AREDIA
- ☐ BLOOD THINNERS
- ☐ DIDRONEL
- ☐ BONIVIA
- ☐ ZOMETA

## Medical Conditions: *PLEASE CHECK ALL THAT APPLY*

- ☐ HIGH BLOOD PRESSURE
- ☐ ORGAN TRANSPLANT
- ☐ ENDOCARDITIS
- ☐ STOMACH/INTESTINAL DISEASE
- ☐ FAINTING
- ☐ SEIZURES
- ☐ HEART ATTACK
- ☐ CONGENITAL HEART DISEASE
- ☐ HEART STENTS/VALVE REPLACEMENT
- ☐ CARDIAC PACEMAKER
- ☐ STROKE
- ☐ RADIATION THERAPY
- ☐ CANCER
- ☐ ANGINA
- ☐ ANEMIA
- ☐ RESPIRATORY PROBLEMS
- ☐ ASTHMA
- ☐ KIDNEY DISEASE
- ☐ DIABETES
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ HPV
- ☐ AIDS/HIV
- ☐ COLD SORES/ FEVER BLISTERS
- ☐ JAUNDICE
- ☐ JOINT REPLACEMENT
- ☐ DENTAL IMPLANT

## PLEASE LIST ALL MEDICATIONS

_____

_____

## DENTAL HISTORY

- ☐ Do your gums bleed while brushing or flossing?
- ☐ Are your teeth sensitive to hot or cold liquids/foods?
- ☐ Are your teeth sensitive to sweets?
- ☐ Do you feel pain in your teeth?
- ☐ Do you have any sores or lumps in your mouth?
- ☐ Have you ever experienced any of the following in your jaw?

  ☐ Clicking ☐ Pain ☐ Difficulty in Opening/Closing ☐ Difficulty Chewing

- ☐ Do you Clench or Grind your teeth?
- ☐ Do you bite your lips or cheeks frequently?
- ☐ Have you ever had instruction on the correct method of brushing your teeth?
- ☐ Have you ever had instructions on the care of your gums?

## LIST ALL SURGERIES

_____

_____

_____

## SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

SIGNATURE: _____ DATE: _____