



**1 PATIENT INFORMATION**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

SS# \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Married  Widowed  Single  Minor  
 Divorced  Separated  Partnered for \_\_\_\_\_ yrs

Patient Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**2 DENTAL INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependant(s), have insurance coverage with \_\_\_\_\_ 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 charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**3 PHONE NUMBERS**

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

**4 DENTAL HISTORY**

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Loose teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Please mark on "yes" or "no" to indicate if you have had any of the following:	Jaw pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growth in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush your teeth? _____
	Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No	