Bell Dental

Dr. Kenny Bell & Dr. Steven Kaebnick

ABOUT YOU

Today's Date: ____/____/_____

Patient Name: _____

Last First MI

Name you prefer to be called: _____

Birthdate: _____/_____/_____ Age: _____

Social Security Number: _____-_____-_____

Mailing Address: _____

_____

City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone : _____

E-mail: _____

Referred By: _____

Employer: _____

Occupation: _____

Status: __Minor __Single __Married __Divorced __Separated __Widowed

Spouse's Name: _____

Do you have children? ____Yes _____No How Many? _____

WHAT WOULD YOU LIKE TO IMPROVE ABOUT YOUR SMILE?

- ☐ Whiten teeth
- ☐ Straighten teeth
- ☐ Close Spaces
- ☐ Replace silver fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match other teeth
- ☐ Other: _____

_____

Name of previous dentist

_____

City & State

_____

Phone Number

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD AT TIME OF VISIT

Primary Dental Insurance:

Insurance Company: _____

Name of Policy Holder: _____

Insured's Birthdate: _____/_____/_____

Policy Number: _____

Group Number: _____

Social Security Number: _____-_____-_____

Insured's Employer: _____

Is there secondary Dental Insurance? ____Yes ____No

If so, please list Insurance Co. name?_____

____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I authorize release of information to insurance company. I fully understand I am solely responsible for any balance not paid by my insurance company. We request that co-payments and/or full payments (should the insurance company require checks being sent to the insured directly) are paid at the time of service. Convenient payment plans are available if necessary.

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT:

We file your insurance as a courtesy: It is not the responsibility of our office to know about each patient's individual insurance benefits/policies. We would be happy to answer questions you may have, however, please make it a point to familiarize yourself with your insurance.

PLEASE NOTE: A service charge of 3.0% per month (36% annually) will be applied to all past due accounts. There will be a $25.00 service charge applied to all returned checks. Should my account enter collection procedures, I understand that Bell Dental reserves the right to collect any fees incurred in the collection of my account, including but not limited to attorney's fees, collection agency fees and billing fees. There will be a $45.00 fee assessed for any late cancellations (24 hrs. or less) or failed appointments.

TREATMENT AUTHORIZATION: I hereby authorize the Dentists and staff at Bell Dental to administer dental treatment to the best of their professional knowledge, and to administer such drugs or anesthetic agents as they deem necessary in said treatment or in an emergency situations.

Signature: _____ Date:____/____/____

Bell Dental Medical History

Patient Name: _____ Date: ____/____/____

Medical History *(Please check any of the following that apply to you): YES/NO*

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Diabetes: Type 1 Type 2
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Heart Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Anxiety/Depression
- ☐ Pacemaker
- ☐ Pregnant (*currently*)
  Due Date _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stent
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco User (*currently*)
- ☐ Tuberculosis
- ☐ Tumors

Please list any and all other conditions not mentioned above that you are being currently being treated for:

_____

_____

Allergies - Are you allergic to or have you had a reaction to *(Please check all that apply and list type of reaction)*:

- ☐ Local Anesthetics _____
- ☐ Aspirin _____
- ☐ Penicillin or other antibiotics _____
- ☐ Sedatives/Sleeping pills _____
- ☐ Sulfa Drugs _____
- ☐ Codeine or other narcotics _____
- ☐ Metals _____
- ☐ Latex (*rubber*) _____
- ☐ Iodine _____
- ☐ Hay Fever/Seasonal _____
- ☐ Animals _____
- ☐ Food _____
- ☐ Other (please list): _____

Other Medical Information (*Please circle YES or No*):

- Have you had Joint Replacement? YES☐ NO☐ Date: ____/____/____ Any Complications? YES☐ NO☐ Not Applicable☐
- Do You Require Pre-Medication Prior to any dental treatment? YES☐ NO☐
- Are you taking or scheduled to begin taking Bisphosphonate medication (such as Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)? YES☐ NO☐
- Are you Currently under Pain Management or have a Pain Manager? YES☐ NO☐
- Are you currently on any Blood Thinners (Coumadin, Warfarin, Clopidogril/Plavix, Xerelto, Eliquis)? YES☐ NO☐

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION AND OVER THE COUNTER)

Name of Medication	Dosage	Name of Medication	Dosage

Name of Family Doctor: _____ Phone: _____

Patient/Parent Signature: _____ Date: ____/____/____

Doctor Signature: _____ Date: ____/____/____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____