CLIFFORD R. BELL, DDS, INC.

General Dentistry Emphasizing Family, Cosmetic, & Implant Supported Dentures and Crowns

REGISTRATION AND HEALTH HISTORY

Patient's Last Name First MI Preferred Name Sex Age Marital Status

Street Address City State Zip Home Phone

__/__/__ __-__-__

Patient's Birth Date Social Security Number E-mail Cell Phone

Employer Business Phone Dental Insurance Company Ins. Subscriber

Dental Insurance Address Ins. Phone Group #

Spouse/Parent/Guardian Birth Date / / Social Security Number - - Employer Business Phone

It is important that we know about your medical & dental history as many things may have a direct bearing on your Dental Health. We will review the questionnaire & discuss it with you in detail, if necessary. ***By my signature below, I understand the following: 1) This history will not be released without my permission.***

2) I consent to treatment & am responsible for all fees regardless of insurance.

YOUR DENTAL HISTORY

Former Dentist_____ Phone_____ Last Visit_____

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH ?_____

Please explain any difficulty in the past with dental treatment._____

What are your fears of dentistry, if any?_____

YOUR MEDICAL HISTORY

Physician's Name_____ Phone_____

Are you presently or have you been under the care of a physician during the last year? Yes____ No____

If yes, please explain._____

List all allergies to DRUGS, FOODS, LATEX (RUBBER), METALS, etc._____

Have you been instructed by your Physician to **Premedicate with Antibiotics**?_____ **Reason?**_____

List any medications you are now taking(**For Example FOSOMAX, ACTINOL, etc**) ?_____

Have you ever had or been suspected of having any of the following? **Please read each item carefully & *INITIAL ONLY if yes***.

__Allergic to Ibuprofen
__Allergic to Latex
__Allergic to Metals
__Allergic to Any Anesthetics
__Allergic to Penicillin
__Anemia
__Asthma
__Aspirin Therapy
__Arrhythmia(Irregular Heart Beat)
__Blood Disease
__**Cancer Therapy**
__Crohn's Disease
__**Taking FOSOMAX or ACTINOL**

__Colitis
__**Diabetes-Type I**
__Epileptic Seizures
__Fainting Tendency
__**Heart Murmur**
__**Heart Problems**
__**Hemophilia**
__Hepatitis
__**HIV Positive**
__High Blood Pressure
__**Joint Replacement**
DATE_____

__TMJ/Jaw Problems
__Kidney or Bladder Problems
__**Lupus Erythematosus**
__**Mitral Valve Prolapse**
__Operations
__Orthodontics (braces)
__Pacemaker
__Periodontal Surgery
__Radiation Treatments
__Respiratory Problems
__**Rheumatic Fever**
__**Rheumatoid Arthritis**
__**Previous Joint Infection**

__Sinus Problems
__Stomach Problems
__Stroke
__Substance Abuse
__Tuberculosis
__Any Back Problems
__Oral Piercing
How long since piercing?
_____
__Other Problems_____
_____
_____

DATE _____ **SIGNATURE**_____

Who may we thank for referring you to our office?_____