

Patient Information (CONFIDENTIAL)



How did you hear about us? _____

Bel Drive Dental can now confirm appointments by email or text. Please check your preference:

Email Text Home Phone Cell Phone

Are you interested in our in-house payment program through Care Credit, Cherry Finance, or Sunbit Finance ?

Yes No

Check this box if you agree to receive commercial electronic messages from Bel Drive Dental. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

Name _____ Birthdate _____ Home Phone _____ M F
Address _____ City _____ State _____ Zip _____
Email _____ SS# _____ Cell Phone _____
If Full Time Student, Name of School/College _____ City _____ State _____
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Emergency Contact _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Birthdate _____ Email _____ Cell Phone _____
Employer _____ Work Phone _____ SS# _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____
1. Have you ever been diagnosed with periodontal disease? _____
2. Have you ever been told that you snore? _____
3. Do you like your smile? _____ How would you rate your smile on a scale from 1-10? _____
4. What changes would you make to improve your smile? _____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____
Relationship to Patient _____
Birthdate _____
SS#/ID# _____
Name of Employer _____
Insurance Company _____
Group # _____
Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____
Relationship to Patient _____
Birthdate _____
SS#/ID# _____
Name of Employer _____
Insurance Company _____
Group # _____
Policy ID # _____

Patient Medical History

Printed Patient Name: _____

Do we need to update your contact information? _____

Primary Care Physician: _____ Last Exam Date: _____

Yes No

1. Are you under medical treatment now?

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?

If yes, please explain: _____

3. Are you taking any medication(s) including non-prescription medicine?

If yes, what medication(s) are you taking? _____

4. **PRE-MED** Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment?

If yes, do you have any of the following:

Artificial Heart Valve Congenital Heart Defect
 Infective Endocarditis Organ Transplant

OTHER: _____

5. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocaine)
 Penicillin or any other Antibiotics (Please list)
 Sulfa Drugs
 Codeine / Narcotics
 Acrylics
 Food Allergies
 Aspirin
 Any Metals (e.g Nickel, Mercury, etc.)
 Latex Rubber

OTHER (Please list): _____

6. SLEEP

a) Have you been told/know you snore?
 b) Do you have troubles sleeping?
 c) Do you clench or grind your teeth?
 d) Do you have sleep apnea?

7. Do you use tobacco / e-cigarettes?

8. Do you use controlled substances?

9. **Are you taking any blood thinners?**

If Coumadin (Warfarin), most recent INR: _____

Yes No

10. **Are you taking any bone strengthening medications (bisphosphonates)?**

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?

12. Do you have any special needs/requirements that we should be aware of in order to accommodate you better?
(i.e. ASD- Autism Spectrum Disorder/SPD- Sensory Processing Disorder, high anxiety, etc.)

13. Do you have or have you had any of the following?

	Yes	No		Yes	No
AIDS or HIV Infection..	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/		
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure...	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement.....	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			Date: _____		
Cardiac Pacemaker /			Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator.....	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure...	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Most Recent A1C: _____			Respiratory Problems..	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
GERD / Acid Reflux.....	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____			Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____		
Type: _____			_____		

14. WOMEN ONLY:

a) Are you pregnant or think you may be pregnant?
If yes, due date: _____
 b) Are you nursing?
 c) Are you taking oral contraceptives?

15. SIGNATURE REQUIRED:

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____

Date: _____



Acknowledgement of *Notice of Privacy Practices*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have read and may request a copy of Bel Drive Dental's *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that Bel Drive Dental restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand Bel Drive Dental is not required to agree to my requested restrictions, but if in agreement, Bel Drive Dental is bound to abide by such restrictions.

Signature: _____ **Date:** _____

I give my permission to discuss my dental treatment (including, but not limited to: Treatment, Scheduling, Billing, Insurance) with the following groups or individuals: _____

Signature: _____ **Date:** _____