

Family and Cosmetic Dentistry

Wallace J. Bellamy, DMD

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Welcome to our family and cosmetic dentistry practice. Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Patient name: _____ Date: _____
Gender (M/F): _____ Marital Status: _____ Birth date: _____ Social Security #: _____
Driver's License #: _____ E-mail Address: _____
Address: _____ City: _____ State _____ Zip Code: _____
Phones #'s: Home: _____ Work: _____ Ext: _____ Cell: _____

Referral Information

Name of person, office or other source referring you to our practice: _____

Responsible Party Information

Name: _____ Date: _____
Gender (M/F): _____ Marital Status: _____ Birth date: _____ Social Security #: _____
Driver's License #: _____ E-mail Address: _____
Address: _____ City: _____ State _____ Zip Code: _____
Phone: Home: _____ Work: _____ Ext: _____
Employer name: _____
Address: _____
City: _____ State _____ Zip Code: _____ Phone: _____ Ext: _____

Insurance Information

Primary Carrier:

Name of Insured: _____ Insured's Birth date: _____
Social Security #: _____ Group #: _____
Insured's Address: _____
City: _____ State _____ Zip Code: _____
Insured's employer name: _____
Employer address: _____ City: _____ State _____ Zip Code: _____
Insurance plan name: _____
Address: _____ City: _____ State _____ Zip Code: _____
Phone: _____

Patient's relationship to insured Self Spouse Child Other

Secondary Carrier:

Name of Insured: _____ Insured's Birth date: _____
Social Security #: _____ Group #: _____
Insured's Address: _____
City: _____ State _____ Zip Code: _____
Insured's employer name: _____
Employer address: _____ City: _____ State _____ Zip Code: _____
Insurance plan name: _____
Address: _____ City: _____ State _____ Zip Code: _____
Phone: _____

Patient's relationship to insured Self Spouse Child Other

FOUNTAIN PLAZA FAMILY DENTAL

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Dental History Information

Date: _____

Date of last dental visit: _____

What was done at your last visit? _____

What is the reason for your visit today? _____

Name of your previous dentist: _____ Phone: _____

When did you last have your teeth cleaned? _____

When was your last full mouth series of X-rays? _____

Are your teeth sensitive to **(circle all that apply)** Hot, Cold, Sweets, Biting pressure.

Have either of your parents experienced gum disease or tooth loss? YES NO

Does food get caught between your teeth? - YES NO

Where? _____

Do you clench or grind your teeth? YES NO

Do you breathe primarily through your mouth? YES NO

Do you smoke or chew tobacco? YES NO

If yes, how many packs/cans a day? _____

Have you experienced any clicking or popping in your jaw joint? YES NO

Does your jaw ever hurt? YES NO

Has your jaw ever "locked", so that you could not open or close it? YES NO

Are you satisfied with the appearance of your teeth? YES NO

If no, why? _____

Do you feel nervous about having dental treatment done? YES NO

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? YES NO

What happened? _____

Have you ever been treated for gum disease? YES NO

How long ago? _____

Have you ever had orthodontic treatment? (Braces) YES NO

How long ago? _____

Have you ever had any serious injuries to you mouth or jaw? YES NO

What happened? _____

Is there anything else you would like us to know about your dental health or dental history? YES NO

Please list: _____

Medical History Information

Do you have a personal physician?

YES NO

Physician's name: _____

Address: _____

Phone: _____

Are you currently taking any medications? Please list (even over-the-counter medications)

Have you ever had any of the following medical problems? Place a \checkmark if you have any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Surgery/disease/attack | <input type="checkbox"/> Artificial joints (hip, knee, etc.) | <input type="checkbox"/> Hemophilia/Abnormal bleeding |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sickle cell disorder |
| <input type="checkbox"/> Heart murmur, Mitral valve prolapse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial heart valve or pace maker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Aids/HIV+ |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Cold sores or fever blisters |
| <input type="checkbox"/> Have you taken cortisone medicine | <input type="checkbox"/> Allergies or hay fever | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Claustrophobia |
| | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Severe headaches |
| | <input type="checkbox"/> Cancer, chemotherapy/radiation therapy | <input type="checkbox"/> Epilepsy, Seizures/Fainting spells |

Have you ever taken Phen/Fen, Pondimen, or Redux?

YES NO

If yes, have you seen a cardiologist to evaluate any possible heart valve damage?

YES NO

Complications from dental anesthetics?

YES NO

Are you allergic to any medications or drugs?

YES NO

If so, please list _____

Any other conditions not listed above?

YES NO

If so, please list _____

Do you have a fever?

YES NO

Recent onset of respiratory problems like cough or difficulty in breathing?

YES NO

Recent International travel?

YES NO

If so, where _____

Women:

Are you pregnant? YES NO

How many weeks? _____

Are you nursing YES NO

Whom would you like us to contact in case of an emergency? (Name, relationship, phone numbers) _____

I have answered all the above questions to the best of my knowledge. If you need additional information from other healthcare providers, I authorize the release of such information to you. I will notify Dr. Bellamy of any changes in my health.

Patient or Guardian's signature and date: _____

Doctor's signature and date: _____