

FOUNTAIN PLAZA FAMILY DENTAL
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

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Children's Dental/Medical History Information

Date: _____
Date of last dental visit? _____
Dentist's Name and telephone #: _____
What was done at the last visit? _____
Has your child complained about dental problems? YES NO
If yes, what complaint? _____
Does your child brush teeth daily? YES NO
Does your child floss daily? YES NO
Any injuries to your child's mouth or jaw? YES NO
If so, please describe: _____
Has your child had any upsetting dental experiences? YES NO
If so, please describe: _____

Medical History

Name of child's Physician: _____ Phone #: _____
Is your child under the care of a physician at this time? YES NO
If so, for what condition? _____
Is your child currently taking any medications? YES NO
If yes, please list: _____
Has your child ever been hospitalized? YES NO
If yes, for what condition and when? _____
Allergies to medications? YES NO
If yes, please list: _____

Has your child had any history or difficulty with any of the following? If yes, please \checkmark .

- | | |
|---|---|
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle cell disorder |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fainting | Please list: _____ |
| <input type="checkbox"/> Heart problems | |

Does your child currently have a fever? YES NO
Recent onset of problems like cough or difficulty in breathing? YES NO
Recent International travel? YES NO
If yes, where? _____

In case of an emergency whom should we contact?

Name: _____ Relationship _____ Phone: _____
Name: _____ Relationship _____ Phone: _____

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.

Parent or Guardian's signature and date: _____
Doctor's signature and date: _____