The Bell Center for Biological Dentistry

For High Level Wellness
& Vibrant Good Looks

Holistic & Restorative Dentistry Patient Information

In order to best serve your needs, please answer every question to the fullest extent possible.

Date: _________________________
Adult Patient: ____ Preferred Name: ________________
Child Patient: ____ Preferred Name: ________________
Emergency Contact: __________________________________ Phone: ________________________

Address: ____
Date of birth: __________________________ Age: ________ Social Security No: _____________________
Home Phone: ___________________________ Work Phone: ______________________________________
Cell Phone: _____________________________ Email Address: ___________________________________
Marital Status: Single Married Divorced Widowed
Occupation: ____
How did you hear about our office?
Friend (name):_____________________ Doctor Referral (name):_______________Internet:_____________
Magazine Ad: _________________ Social Media: __________________Other:_________________________

Insurance Company: _____________________________________ Insurance Phone: ___________________
Subscriber Name: ________________________________ Date of Birth:______________________________
Subscriber Social Security Number: _____________________________ Insurance ID#: _________________
Group #: ____ Group Name:______________________________

What are you here for today? (i.e. tooth ache, amalgam filling removal, TMJ, bad teeth or gums, etc.)
Please write as much as possible. You may continue on the back of this sheet if needed.
1).____
2). ____

Any special problems or special needs? (Allergies, sensitivities to dental materials or smells in the air, etc.)
1). ____
2). ____

When was the last time you saw the dentist? Approx. Date_____________________ Dentist name and telephone number:____
Have you ever seen a dentist for orthodontics? Approx. Date ________________________ If so, what was your treatment for? ____

When did you last have Full Mouth x-rays taken?____

Are you dissatisfied with the way your teeth look? Yes No

Does food constantly get stuck between certain teeth? Yes No

Do you take nutritional supplements or vitamins? Yes No

If yes, what are you taking?

____

____

Did you eat breakfast this morning? Yes No

What did you eat?____

Have you ever had any teeth removed? Yes No

If yes, reason:

____

Do your gums bleed when brushing of flossing? Yes No

Do you have an unpleasant taste or odor in your mouth? Yes No

Do you mostly mouth breath during the day or while sleeping? Yes No

Do you ever have difficulty swallowing food or liquids? Yes No

Do you smoke? Yes No

If yes, how much per day?____

Do you gag easily while in the dental chair? Yes No

Are your teeth/gums sensitive to hot, cold, sweets, chewing or biting? Yes No

How often do you brush your teeth each day and for how many minutes?

____

If patient is a child:

Is this the child's first visit to the dentist? Yes No

Do they thumb suck? Yes No

Do they bite or chew on their tongue or other objects? Yes No

Have they had any orthodontic work? Yes No

Do they mouth breath during the day or night? Yes No

Does your child grind their teeth at night? Yes No

I have read and understand the preceding information. I have answered the questions correctly and honestly to the best of my recollection and ability.

Signature of patient or Guardian: ____

Date: _____________________________

Witness or Treatment Coordinator for Michael Bell, DDS: ____________________________________

Date: _____________________________

The Bell Center for Biological Dentistry

For High Level Wellness
& Vibrant Good Looks

Discontent History

Head, Neck and Back Pain Symptoms

Do you get tension or migraine Headaches? Yes No If so, where, when and how often? ___________
____

Do you frequently have a stiff neck? Yes No If so, how often? ___________________________

Do you have trouble sleeping soundly at night? Yes No Daily, once a week, once a month?___________

Do you take anything to help you sleep better?____

Do you have shoulder discomfort? Yes No

Do you take pain medication? Yes No Please list all and how often: ________________
____

Do your hands, wrists or arms ache? Yes No

Jaw Joint Symptoms

Do your teeth ever feel sore after awakening? Yes No

Do you grind your teeth at night? Yes No

Does your jaw ache when you chew? Yes No

Do you have a family history of TMJ problems? Yes No

Does your jaw hurt when you open really wide? Yes No

Does your jaw ever lock? Yes No

Any clicking, popping or cracking in the jaw joint? Yes No

Any discomfort in the jaw joint? Yes No

Ear & Eye Symptoms

Do you have ear discomfort? Yes No

Do you hear grating noises in your ears while chewing? Yes No

Do you have ringing, buzzing or hissing in ears? Yes No

Do you have itchiness or stuffiness in either ear? Yes No

Do you suffer from loss of hearing? Yes No

Do you get pain in or around the eyes? Yes No

Are there times when your eye sight blurs? Yes No

Do you wear contacts or glasses? Yes No

Trauma or Accidents

Have you ever had a severe blow to the jaw or head? Yes No Explain: __________________________________
____

Have you been involved in any accidents? Yes No Explain: _________________________________
____

Any whiplash injuries? Yes No Explain: __________________________________
____

Do you ever get dizzy or faint? Yes No How often? _______________________________

Do you ever experience motion sickness? Yes No

Breathing

Do you have any allergies? Yes No To what? ________________________________

Do you have any sinus problems? Yes No

Do you snore at night? Yes No

Is your nose stuffed up even without a cold? Yes No

Name: _______________________________________ Date: ____

Signature of Patient of Guardian: ____

Patient Health History

Approx. date of last physical exam: ________________________________

Has there been any change in your health in the last 5 years?____

____

Are you under the care of a physician, chiropractor or psychologist? Yes No

Name(s) of provider:____

If so, what condition(s) are you being treated for?

____

Have you had a serious illness, injury or operation in the past 5 years? Yes No

If so, what? ____

Do you have any of the following presently or in the past? Please circle all that apply:

Abscesses	Acquired Immune Deficiency	Anemia	Allergies
Arthritis	Artificial prosthesis	Asthma or Hay fever	Blood Diseases
Bruise Easily	Bulimic	Cancer	Chronic Pain
Cortisone Medication	Diabetes	Emphysema	Epilepsy
Excessive Bleeding	Fainting spells	Glaucoma	Gum Disease
Head injury	Heart Disease	Heart Murmur	Hepatitis
Herpes	H/L Blood Pressure	Implants	Jaundice
Heart valve replacement	Kidney disease	Liver disease	Mitral Valve Prolapse
Neck pain or injury	Nervous disorders	Transplants	Pacemaker
Pregnancies / Pregnant	Cancer Treatment	Respiratory disease	Rheumatic fever
Seizures	Sinus trouble	Spinal cord injury	Stomach Ulcers
Stroke	Thyroid disease	TMJ / TMD	Tooth Extractions
Tuberculosis	Tumors or Growths	Venereal Disease	

Others:____

Are you taking any medications presently? Yes No

Please list medications if any.

____

____

Are you allergic to any medications: Yes No

Penicillin

Codeine

Sulfa

Novocain

Other: ____

Is there anything else we should know about your health? ____

____

Signature of Patient or Guardian: ____

Date: ____

The Bell Center for Biological Dentistry

For High Level Wellness
& Vibrant Good Looks

Introduction

Upon graduation from Baylor College of Dentistry in 1988, Dr. Bell began attending post-graduate courses in a wide variety of subjects, including craniomandibular dysfunction, orthodontics, occlusal disease, orthopedics, chirodontics and the study of structural planes and forces within the body. Chirodontics plays an important role in the focus of treatment at The Bell Center for Biological Dentistry, and ultimately in your health.

Looking at the entire body in relation to dental condition and vice versa is part of what classifies him as a “Holistic” or “Structural Dentist”. Many problems such as tooth wear, decay, shifting of the teeth or poor fitting dentures are the result of problems with the structural alignment of the body, overall nutrition and supplementing, and past trauma or inadequate dental work. Unfortunately, this approach is still the exception rather than the rule in Dental Practices. As the Chirodontic approach is becoming more popular, medical students are learning how the jaw and teeth support the skull and dental students are learning the impact of the jaw on the spine, head and the rest of the body systems. Hopefully you will learn something new today and be open to thinking differently about your teeth in relation to your whole body.

We strive to make our office a comfortable environment for you and your entire family. We will do our best to accommodate any individual needs or address any concerns you may have. Welcome to our office.

We feel the following information will be helpful to you as a client within our office:

Fees and Payment

In an effort to provide the best quality care, The Bell Center for Biological Dentistry is not a high-volume insurance office. We limit the number of patients we see each day in order to give you the time and attention you deserve. To provide this care, payment is due at the time services are rendered. Fees depend on the length of time spent and complexity of diagnosis and treatment. All charges will be discussed with you after your consultation with Dr. Bell to determine a plan of treatment. There is a $25 returned check fee.

Insurance

We will submit claims to your insurance company for services provided. Keep in mind your insurance policy is a contract between you and your insurance company, and does not guarantee payment or reimbursement. We highly recommend that you contact your Insurance Provider to confirm coverage and benefits. Any unpaid balance after your insurance company has processed the claim will be the patient’s responsibility.

X-Rays

Radiographs taken in the office are the diagnostic tool used by the Doctor to make a proper diagnosis and determine a course of treatment. Original radiographs are the property of the Doctor and the office. Digital copies of radiographs taken in this office may be requested and are available on paper or email. Original radiographs will not be released to patients. If the patient had x-rays taken at a special or discounted rate, copies will be released for a fee of $50.

Appointments

In an effort to keep our practice running as on time and smoothly as possible, we ask that you be on time for your appointments. We may ask that you put a deposit down on all appointments that require additional time. We will inform you when making your appointment if a deposit is required.

As our time and yours is valuable we require at least a 48 hour notice of cancellation. A $50.00 cancellation fee may be applied if less than 48 hour notice is given.
I have read and understand The Bell Center for Biological Dentistry’s policies and procedures, and would like to receive services under the above policies.

Signature of Patient or Guardian: ____ Date:____________________

Proprietor Guarantee

By signing this Agreement I/We acknowledge that I/We have personally guaranteed the debts and obligation incurred by the undersigned, and agree that I am personally obligated to perform all of the terms of and make all payments to Dr. Michael Bell required by the Agreement of which this Application is a part. I/We hereby consent to and authorize all services. I/We hereby agree to inform this office of any changes in my/our address as it may occur. I/We authorize this office to release any necessary information to third parties, when requested and if we become delinquent and my account is assigned to your Collection Agency associate they are hereby given the right to report same accurately to all the Credit Bureaus.

AGREEMENT OF FINANCIAL RESPONSIBILITY

I/We agree to pay all collection expenses the Practice may incur in collection of our delinquent balance, plus $25 returned check fee, attorney's fees, court costs, including charges or commissions that may be assessed by any collection agency retained to pursue this matter. Collection Fees will be 40% for Regular Collections and 50% for Legal Collections or Forwards, which may be as much as twice the original principal balance owing. Patient further agrees to pay interest rate of 24% per year from the first date the account becomes delinquent.

Credit information must be used for permissible purposes only. Unauthorized access a crime and may result in criminal prosecution. Customers are required to retain supporting documentation for each transaction.

I/WE CERTIFY WE HAVE READ AND UNDERSTAND ALL THE INFORMATION PROVIDED. I/WE CERTIFY THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.

____

SIGNATURE OF RESPONSIBLE PARTY   SOCIAL SECURITY NUMBER   DATE

____

SIGNATURE OF RESPONSIBLE PARTY   SOCIAL SECURITY NUMBER   DATE

H.I.P.P.A. COMPLIANCE: Our office, Staff, and Associates are conversant with and abide by the Rules, Regulations and Statutes relevant to the protocols of law regarding the Federal Law governing the protections of individual consumer privacy.

PRIVACY POLICY: We do not share "Non Public Information" with any "third parties or Entities." All information provided shall be kept confidential and secure.