Dr. Alonzo M. Bell, DDS, FAGD

1454 Duke Street
Alexandria, VA 22314

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ____ Preferred name __________________ Birth date________________

Email ____________________________________ Home phone _______________ Cell phone ____________________

Mailing address ______________________________________ City ____________________State ______ Zip ___________

Employer _________________________________ Occupation ___________________________ Married ______ Single ______

Your Social Security number: _____________________

Whom may we thank for referring you to our office? ____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Are you the Policy Holder? ❑ yes ❑ no

Dental Insurance Co.______________________ ID Number_________________

Subscriber birthday ______________________ Social Security number ____________________________

DENTAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

DENTAL HEALTH HISTORY

Do you brush? ❑ yes ❑ no

Do you floss? ❑ yes ❑ no

Do your gums bleed easily? ❑ yes ❑ no

Do your gums bleed when you floss? ❑ yes ❑ no

Do you avoid brushing any part of your mouth because of pain?

❑ yes ❑ no

Do you clench or grind your jaws frequently? ❑ yes ❑ no

Do you have any jaw symptoms or headaches upon awaking in the morning? ❑ yes ❑ no

Are you apprehensive about dental treatment? ❑ yes ❑ no

Does food catch between your teeth? ❑ yes ❑ no

Are your teeth sensitive? ❑ yes ❑ no

Do you feel twinges of pain when your teeth come in contact with: (circle all that apply)

Hot foods or liquids　Sours

Sweets　Cold foods or liquids

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_______________________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)

Antibiotics or sulfa drugs

- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_______________________________________

Women:

- ❑ Pregnant

Expected delivery date: _____________

MEDICAL HEALTH HISTORY

(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Other:_______________________________________

Name of your physician:____

Do you have any disease, condition, or problem not listed above?____

____

Please add anything else you would like us to know about:____

____

Signature of patient (or parent) ______________________________ Date ______________