GENERAL DENTISTRY
Todd Bellem
ON THE PLAZA

www.drbellem.com

13163 State Line
Kansas City, Missouri 64145

(816) 931-5320

Today's Date

Patient Information Form

Name

If Child, Parent's Name

If Child, Parent's Social Security #

Patient's Date of Birth

Patient's Social Security #

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married

Residence

Street

City State ZIP

Phone Cell

Driver's License #

Other family members in this Practice

Business (Patient or Parent)

Employer

Position

Street

City State ZIP

Phone FAX

Spouse's Name

Spouse's Employer

Emergency Contact (include phone #)

Whom may we thank for this referral?

Patient Name _____

Office Use Only

Dental Insurance - 1st Coverage

Employee Name

D.O.B. Social Security #

Employer Name

Street Yrs.

City State ZIP

Phone #

Program or Policy #

Union Local or Group

Dental Insurance – 2nd Coverage

Employee Name

D.O.B. Social Security #

Employer Name

Street Yrs.

City State ZIP

Phone #

Program or Policy #

Union Local or Group

Release:

I hereby authorize the release of the following:

- Any information concerning my (or my child's) health care, advice, and treatment to another dentist.
- Any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize the following:

- Dentist to perform diagnostic procedures and treatment as necessary for proper dental care.
- Payment of insurance benefits directly to the Dentist, otherwise payable to me.

I understand that my dental insurance carrier or payor of benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of my accounts. With my signature below, I revoke any previous agreements that are contrary to this one and agree to take responsibility for any unpaid services not paid for by my dental care payor.

Patient or Guardian's Signature Date

Patient Medical History Form

The following information is for our records only and will be kept confidential

Patient's Name _____ Date of birth _____

If you are completing this form for another person, what is your relationship to the patient? _____

Are you in good health?	☐ Yes ☐ No	Have you ever had an operation or serious illness?	☐ Yes ☐ No
Has there been a change in your health in the past year?	☐ Yes ☐ No	Are you now under the care of a physician?	☐ Yes ☐ No
Date of your last physical exam		If so, what is your ailment?	

Current Physician Info (if applicable)

Name _____ Street _____

City _____ State _____ ZIP _____ Phone _____

Are you taking any medications (prescription or non)? ☐ Yes ☐ No

Please list any medications you are taking and the relating condition.

Have you ever had an allergic reaction to any drug or medicine? If so, explain	☐ Yes ☐ No	Do you ever have spontaneous bleeding from the nose, mouth, joint, intestine, stomach, vagina, or urinary tract? If so, explain	☐ Yes ☐ No
Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? If so, explain	☐ Yes ☐ No	Do any family members have a bleeding problem? If so, explain	☐ Yes ☐ No
Do you have chest pain upon exertion?	☐ Yes ☐ No	Do you urinate more than 6 times a day?	☐ Yes ☐ No
Do your ankles swell?	☐ Yes ☐ No	Are you thirsty much of the time?	☐ Yes ☐ No
Are you short of breath after mild exercise?	☐ Yes ☐ No	Does your mouth frequently become dry?	☐ Yes ☐ No
Do any of your family members have diabetes? If so, explain	☐ Yes ☐ No	Do you smoke? If so, how much?	☐ Yes ☐ No
Do you consume alcohol? If so, how much?	☐ Yes ☐ No		

Do you have or have you ever had any of the following conditions:			
Rheumatic Fever	○ Yes ○ No	Arthritis	☑ Yes ○ No
Heart Murmur	☐ Yes ☐ No	Cold Sores	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Mouth Ulcers	☐ Yes ☐ No
Heart Disease/Attack	☐ Yes ☐ No	Pain in Jaw Joint	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No	Alcohol/Drug Abuse	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Artificial Joint	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Easily Bruised	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Epileptic Seizures	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	ARC	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Tumors	☐ Yes ☐ No	Please list any condition you have that is not listed above.	
Thyroid Disease	☐ Yes ☐ No		

Women Only			
Are you pregnant?	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No

If you have additional health information that has not been addressed here, please do so during your visit with the Doctor today.

Please sign below:

To the best of my knowledge, all of the preceding information I have given is correct. If I have a change in my health, or medication, I will inform the Doctor at my next appointment.

Signature of Patient/Guardian **Date**

Signature of Doctor Date