ELIZABETH A. BELL, DDS.
NICHOLAS R. THOMPSON, DMD.
525 High School Road NW Bainbridge Island, WA 98110
(206) 842-4794

DATE_____

PATIENT NAME_____ BIRTH DATE_____

PATIENT SS#_____ HOME PHONE_____

EMAIL ADDRESS _____

HOME ADDRESS_____

_____

BILLING ADDRESS_____

_____

EMPLOYER_____ BUSINESS PHONE_____

SPOUSE NAME_____ BIRTH DATE_____

EMPLOYER_____ BUSINESS PHONE_____

INSURANCE

PRIMARY INSURANCE_____ GROUP#_____

SUBSCRIBER'S NAME_____ SS#_____

SUBSCRIBER'S BIRTH DATE_____

ARE ALL FAMILY MEMBERS COVERED?_____

SECONDARY INSURANCE_____ GROUP#_____

SUBSCRIBER'S NAME_____ SS#_____

SUBSCRIBER'S BIRTH DATE_____

ARE ALL FAMILY MEMBERS COVERED?_____

DENTAL HISTORY

NAME OF PREVIOUS DENTIST_____ LAST VISIT_____

HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL TREATMENT?_____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?_____

_____

I CERTIFY THAT I HAVE COMPLETED AND UNDERSTAND THE ABOVE. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENTS OR EXAMINATIONS RENDERED TO MY INSURANCE COMPANY OR COMPANIES AND WILL NOT HOLD MY DENTIST, OR ANY MEMBER OF THE STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS. THIS RELEASE IS SOLEY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT DIRECTLY TO THE DOCTOR OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THIS FORM.

SIGNATURE_____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK.

_____**HEART PROBLEM**
_____CHEST PAIN
_____SHORTNESS OF BREATH
_____BLOOD PRESSURE PROBLEM
_____CHOLESTEROL
_____**HEART VALVE PROBLEM (MVP)**
_____**HEART MURMUR**
_____**TAKING HEART MEDICATION**
_____**RHEUMATIC FEVER**
_____**PACEMAKER/DEFIBULATOR**
_____**ARTIFICAL HEART VALVE**
_____**PREMEDICATION REQUIRED BY MD**

_____**BLOOD PROBLEMS**
_____EASY BRUSING
_____FREQUENT NOSE BLEEDS
_____ABNORMAL BLEEDING
_____BLOOD DISEASE (ANEMIA)
_____BLOOD TRANSFUSION

_____**ALLERGY PROBLEMS**
_____HAY FEVER
_____SINUS PROBLEMS
_____SKIN RASHES
_____TAKING ALLERGY MEDICATIONS
_____ASTHMA

_____**INTESTINAL PROBLEMS**
_____ULCERS
_____WEIGHT GAIN OR LOSS
_____SPECIAL DIET
_____CONSTIPATION/DIARRHEA
_____KIDNEY OR BLADDER PROBLEMS

_____**BONE OR JOINT PROBLEMS**
_____ARTHRITIS
_____BACK OR NECK PAIN
_____JOINT REPLACEMENT

_____FAINTING SPELLS OR SEIZURES
_____FREQUENT OR SEVERE HEADACHES
_____THYROID PROBLEMS
_____PERSISTANT COUGH, SWOLLEN GLANDS
_____**PREMEDICATIONS REQUIRED BY MD**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?
_____LOCAL ANESTHETIC
_____PENICILLIN OR ANTIBIOTICS
_____BARBITURATES, SLEEPING PILLS
_____ASPIRIN, ACETAMINOPHEN, IBUPROFIN
_____CODEINE, DEMEROL
_____REACTION TO METALS
_____LATEX OR RUBBER DAM
_____OTHER_____
_____

_____**DIABETES**
_____URINATE MORE THAN 6X A DAY
_____THIRSTY OR DRY MOUTH
_____FAMILY HISTORY OF DIABETES

_____**RESPIRATORY DISEASE**

_____**CANCER/TUMOR**

_____DO YOU DRINK ALCOHOL?
IF SO, HOW MUCH?_____

_____DO YOU SMOKE?
IF SO, HOW MUCH?_____

_____**HEPATITIS**
_____JAUNDICE OR LIVER TROUBLE
_____HERPES OR OTHER STD
_____HIV-POSITIVE/AIDS

_____**GLAUCOMA**
_____DO YOU WEAR CONTACT LENSES?

_____HISTORY OF HEAD INJURY?

_____**EPILEPSY**
_____NEUROLOGICAL DISEASE

_____HISTORY OF DRUG ABUSE
_____HISTORY OF ALCOHOL ABUSE

_____**DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED PREVIOUSLY THAT YOU FEEL WE SHOULD KNOW ABOUT?**
IF SO, PLEASE DESCRIBE_____
_____

DURING THE LAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING
_____ANTIBIOTICS
_____ANTICOAGULANTS
_____HIGH BLOOD PRESSURE MEDS
_____TRANQUILIZERS
_____INSULIN OR ORNASE
_____ASPIRIN
_____DIGITALIS OR HEART MEDS
_____NITROGLYCERIN
_____CORTISONE
_____OTHER MEDICATIONS_____
_____
_____

WOMEN:
_____ARE YOU PREGNANT?
_____TAKING BIRTH CONTROL PILLS
_____HORMONE THERAPY

PLEASE INITIAL WHEN FINISHED_____