Travis A Bell DDS PLLC

Family, Cosmetic, and Implant Dentistry
Drs. Travis A Bell DDS & Janna C Civils DDS

Welcome to our dental practice and thank you for entrusting us with your oral health. Upon arriving at our office, you can expect a warm welcome and pleasant experience. During your new patient appointment, we will complete all of the items below. If radiographs "X-rays" have been taken at another dental practice or specialist office such as an Oral Surgeon (Wisdom teeth removal) or Orthodontist (Braces/Invisalign) in the past 5 years please request those radiographs "X-rays" be sent to our practice prior to your appointment.

New Patient Appointment Expectations

- You will be welcomed to our practice by your new Dental Hygienist and Dentist
- Radiographs "X-rays", which are not current will be updated
- Periodontal probing records will be obtained to evaluate your "gum" health
- Dental prophylaxis "cleaning" will be completed
- Thorough assessment of your bite and TMJ (jaw joint)
- Detailed evaluation of your teeth, gums and bone surrounding your teeth
- Video "tour of your mouth" with our intraoral camera system

To make sure you are seen promptly, please complete the attached patient information forms within three days. Once completed please return the form via email to drtravisbell@gmail.com. Visit our website to learn more about our office at www.travisbelldds.com. Feel free to contact our office with any questions by calling (336) 274-8386. We look forward to meeting you and welcoming you as a new patient to our dental family.

Sincerely,

Drs. Travis A Bell DDS, Janna C Civils DDS, and team

Travis A Bell DDS PLLC 526 N Elam Ave Suite 201 Greensboro, NC 27403 www.travisbelldds.com
Email: drtravisbell@gmail.com Phone 336-274-8386 Fax 336-274-8375

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip code

Cell Phone: ❒Primary Home Phone: ❒Primary Work Phone: ❒Primary

Email Address: Social Security #

Birth Date: (Month / Day / Year) Birthplace:

Employer: Occupation:

Insurance

Insured Person's: Full Name Date of Birth

Relationship to Patient Social Security # (of card holder) Insurance Company Name

Employer's Name Group # Subscriber ID (if assigned)

Getting To Know You

1. How did you hear about our office?
2. Whom may we thank for referring you?
3. Is another member of your family or relative a patient in ourpractice?
4. When was your last dental visit?
5. When was the last time you had dental radiographs taken?
6. Name & phone number of last Dentist
7. Have you ever had orthodontic treatment (braces)?
8. Have you ever had any teeth removed?
   - How long have these teeth been missing?
   - Have these teeth been replaced?
   - How? ❒Bridge ❒Partial ❒Denture ❒Implants
9. Emergency contact: (Name / Relation / Phone)

Payment

1. We accept Mastercard, Visa, Discover, American Express, Care Credit, Personal Checks, or Cash.
2. If you have dental insurance, we want to help you receive your full benefits and will be happy to assist you with this. Our patients are responsible for the account if you insurance company, for any reason, does not honor their commitment to you or us.
3. For long term or extended payments, we accept Care Credit.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any/all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date

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MEDICAL HISTORY

1. How do you feel about the appearance of your teeth?_____
2. If you could change anything about your smile, what would you change?_____
3. Would you like whiter teeth?..... ❒Yes ❒No
4. Are there any changes in your mouth that you are aware of?..... ❒Yes ❒No
5. Do your gums bleed at any time?…..... ❒Yes ❒No
6. Do you feel very nervous about having dental treatment?..... ❒Yes ❒No
7. Have you ever had a bad experience in the dental office?..... ❒Yes ❒No
8. Have you been under the care of a medical doctor during the past two years? If yes: for what reason? ❒Yes ❒No

_____

9. Please provide the name, and telephone number of your physician:

_____

10. Have you been a patient in the hospital during the past two years? If yes: for what reason?..... ❒Yes ❒No

_____

11. Have you taken any medicine or drugs during the past two years? If yes, please list:…….. ❒Yes ❒No

_____

12. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by:
    penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list…….. ❒Yes ❒No

_____

13. Have you ever had excessive bleeding requiring special treatment?..... ❒Yes ❒No
14. Do you use any tobacco products?……..... ❒Yes ❒No
15. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... ❒Yes ❒No
16. Do your ankles swell during the day?… ..... ❒Yes ❒No
17. Have you lost or gained more than 10 pounds in the last year?…..... ❒Yes ❒No
18. Have you ever taken any bone modifying medications for osteoporosis or bone cancer……..... ❒Yes ❒No
19. If so, please circle which one:
    Actonel (Risendronate), Fosamax (Alendronate), Boniva (Ibandronate), Didronel (Etidronate), Aredia (Pamidronate), Skelid (Tiludronate), Reclast (Zoledronic), or Zometa?
20. Do you snore or have trouble sleeping?……..... ❒Yes ❒No
21. Check any of the following which apply in either past or present:

❒Heart Valve Prolapse	❒High Blood Pressure	❒Sleep Apnea
❒Heart Failure	❒Anemia	❒Arthritis
❒Heart Disease or Attack	❒Asthma	❒Pain in Jaw Joints
❒Family History of Cardiovascular Disease	❒Emphysema	❒X-Ray or Cobalt Treatment
❒Angina Pectoris (chest pain)	❒Shortness of Breath	❒Cancer or Tumors
❒Rheumatic Fever	❒Hay Fever	❒Chemotherapy - Cancer/Leukemia
❒Congenital Heart Defects	❒Allergies or Hives	❒Thyroid Disease
❒Scarlet Fever	❒Fainting or Dizzy Spells	❒Glaucoma
❒Artificial Heart Valve	❒Epilepsy or Seizures	❒HIV Positive (AIDS)
❒Heart Pacemaker	❒Nervousness	❒Venereal Disease
❒Heart Surgery	❒Psychiatric Treatment	❒Cold Sores or Fever Blisters
❒Artificial Joint of Any Type	❒Any Form of Eating Disorder	❒Genital Herpes
❒Diet Medication: Name_____	❒Recreational Drug Use	❒Kidney Trouble
❒Heart Murmur	❒Drug Addiction/Alcoholism	❒Diabetes
❒Bruise Easily	❒Tuberculosis (TB)	❒Ulcers
❒Blood Transfusion	❒Any Form of Hepatitis	❒Stroke
❒Hemophilia	❒Liver Disease	❒Birth Control Medication
❒Sickle Cell Disease	❒Rheumatism	❒Pregnant – Due Date_____

22. Do you have any disease, condition or problem not listed? ..... ❒Yes ❒No
    If so, please list _____

_____

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Authorization to Release Information

Name of Patient:_____Date of Birth: _____

Travis A Bell DDS PLLC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.
Please check each person / entity that you approve to receive information, then check the corresponding information that can be released.

- o Voice Mail / Answering Machine, messages at work, home or cell phone.
  - o Insurance, results of radiographs "X-rays"
  - o Appointment Times/Reminders
  - o Other (Explain):
- o Spouse (Provide Full Legal Name) _____Phone #_____
  - o Insurance
  - o Dental / Medical
  - o Financial
- o Parent (Provide Full Legal Name) _____Phone #_____
  - o Give Information to Employer or School (Provide name): _____
  - o Appointment Absentee Information
  - o Appointment Times
- o Other (Provide name & Relationship) _____
  - o Insurance
  - o Dental / Medical
  - o Financial

EMAIL COMMUNICATION WARNING:

Some communications with this office are transmitted by email with the entities below:

- Patient (Example: Appointment reminders, breach notifications, etc.)
- Insurance Companies
- Other dental and medical offices (Example: Prior records, referral information, etc.)

In order for email communication to occur, please accept the following disclosure below:

- I understand that if the information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communication.

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date_____

Signature of Patient or Personal Representative*

*Description of Personal Representatives Authority (Attach Necessary Documentation)

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name & Address:

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ○ An emergency existed & a signature was not possible at the time
- ○ The individual refused to sign
- ○ A copy was mailed with a request for a signature by return mail
- ○ Unable to communicate with the patient for the following reason:
- ○ Other:

Signature of witness: _____

Date: _____

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Dental Records Release Form

Patient Name: _____

Date of Birth:_____Email:_____Phone Number: _____

Other Family MembersTransferring records: _____

Previous Dentist or Practice Name: _____

Previous Practice Address: _____

Previous Practice City / State / ZipCode: _____

Previous Practice Phone Number: _____

Previous Practice Email: _____

Required to obtain any previous radiographs "X-rays"

Please forward the following information obtained within the past 10 years: Radiographs “X-Rays”, Probing depth records, charting records, and photographs to the following practice:

Travis A Bell DDS PLLC
526 North Elam Ave Suite 201
Greensboro, NC 27403
Drtravisbell@gmail.com

I hereby grant permission to release any and all of my dental record to Travis A Bell DDS PLLC

_____ _____

Patient Signature (Parent if a minor) Date

Digital records may be email to:
drtravisbell@gmail.com

Physical records may be mailed to:

Travis A Bell DDS PLLC
526 North Elam Ave Suite 201
Greensboro, NC 27403