bell hill
DENTAL

Welcome to the Bell Hill Dental Centre! We are very pleased that you have selected us to care for your dental needs. We want you to know that we are committed to providing you with the highest quality of oral health care, in the most gentle, efficient and enthusiastic manner possible.

In our dental practice, we give each patient personal and individualized attention. We believe that a close relationship allows you to experience dentistry in the most positive way possible. We are aware that some patients may have uneasiness about dental care and we will make every effort to help relieve any apprehension you may have. In order for us to do this, we must have communication – we need to know **your** wants and needs. We will tailor a treatment plan with options that we will discuss openly with you and in full, so that you can make an informed decision on what is best for **you**. We want our patients to assume an active role in obtaining and preserving their dental health.

Attached you will find our health questionnaire and patient registration form. Please complete, and bring these forms with you to your appointment, or scan and return them via email prior to your appointment.

We request payment at the time of treatment, unless other financial arrangements have been made. We will be glad to help you with financial arrangements for any comprehensive treatment we plan together. Please ask!

We feel strongly that your time is important, and except for emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. Therefore it is important that if you are unable to keep your appointment, that you call us as soon as possible. No charge will be made for rescheduling your appointment provided 24hrs advance notice is given.

Our dental team is highly skilled and motivated to make your dental experience as pleasant and comfortable as possible. If at any time you have a question about any treatment, fee, or service, please feel free to discuss it with any of our staff promptly and openly. We look forward to meeting with you soon!

Kindest regards

Elaine Neill and the entire team at Bell Hill

Dental History

Patient Name:_____ Medical Alert: _____

What is the reason for your visit today? _____
Date of last dental visit _____Last dental cleaning _____Last full mouth x-rays _____
What was done at your last visit?_____
Previous Dentist Name_____
Address_____
How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss?_____
What other aids do you use? (interdental brushes, toothpicks etc)_____
Do you have any dental problems now? Yes/No
If yes, please describe:_____
How did you find out about Bell Hill Dental? _____
Were you referred by an existing patient? Y/N
If yes: who can we thank for referring You? _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes/No
Sweets?	Yes/No
Biting or Chewing?	Yes/No
Have you ever noticed mouth odours or bad tastes?	Yes/No
Do you frequently get sores, blisters or any other oral lesions?	Yes/No
Do your gums bleed or hurt?	Yes/No
Have your parents experienced gum disease or tooth loss?	Yes/No
Have you noticed any loose teeth or change in you bite?	Yes/No
Does food tend to become caught between your teeth?	Yes/No

If yes; where? _____

Do You:

Clench or grind your teeth while awake or asleep?	Yes/No
Are you satisfied with your teeth's appearance?	Yes/No
Would you like to keep all of your teeth all of your life?	Yes/No
Do you feel nervous about having dental treatment?	Yes/No

If so, what is your biggest concern?

_____
_____

Have you ever had:

Orthodontic Treatment?	Yes/No
Oral Surgery?	Yes/No
Periodontal Treatment?	Yes/No
Your teeth ground or the bite adjusted?	Yes/No
A bite plate or a mouth guard?	Yes/No
A serious injury to the mouth or head?	Yes/No
Any previous problems with dental infections? If so, please describe, including cause?	Yes/No

Have you experienced:

Clicking or popping of the jaw?	Yes/No
Pain (joint, ear, side of face)?	Yes/No
Difficulty in opening or closing the mouth?	Yes/No
Difficulty in chewing on either side of the mouth	Yes/No
Headaches, neck aches, or shoulder aches?	Yes/No
Sore Muscles (neck, shoulders)?	Yes/No

Have you ever had an upsetting dental experience? Yes/No

If Yes, please describe_____
_____

Is there anything else about having dental treatment that you would like us to know? Yes/No

If yes, please describe:

_____

_____

Is there any cultural or religious needs that you would like us to be aware of? Y/N

If yes, please describe:

_____

_____

Medical History

Patient Name: _____ Medical Alert:_____

1.Have you been under the care of a medical doctor during the past two years? Yes/No
If yes what for: _____
Physician's Name:_____ Phone _____

2.Have you taken any medication or drugs during the last two years: Yes/No
3.Are you taking any medication, drugs or pills now? Yes/No
If Yes, please list name and dosage _____

4.Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes/No
If yes please list: _____
5.Have you been a patient in the hospital during the past five years? Yes/No

6.**Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item**.

Heart (surgery, Disease, Attack)	Yes/No	Ulcers	Yes/No	Hepatitis	Yes/No
Chest Pain	Yes/No	Diabetes	Yes/No	Venereal Disease	Yes/No
Congenital Heart Disease	Yes/No	Thyroid Problems	Yes/No	A.I.D.S	Yes/No
Heart Murmur	Yes/No	Glaucoma	Yes/No	H.I.V Positive	Yes/No
High Blood Pressure	Yes/No	Contact Lenses	Yes/No	Cold Sores/Fever Blister	Yes/No
Mitral Valve Prolapse	Yes/No	Emphysema	Yes/No	Blood Transfusion	Yes/No
Artificial Heart Valve	Yes/No	Chronic Cough	Yes/No	Haemophilia	Yes/No
Heart Pacemaker	Yes/No	Tuberculosis	Yes/No	Sickle Cell Disease	Yes/No
Rheumatic Fever	Yes/No	Asthma	Yes/No	Bruise Easily	Yes/No
Arthritis/Rheumatism	Yes/No	Hay Fever	Yes/No	Liver Disease	Yes/No
Cortisone Medicine	Yes/No	Latex Sensitivity	Yes/No	Yellow Jaundice	Yes/No
Swollen Ankles	Yes/No	Allergies or Hives	Yes/No	Neurological Disorders	Yes/No
Stroke	Yes/No	Sinus Troubles	Yes/No	Epilepsy or Seizures	Yes/No
Diet (Special/Restricted)	Yes/No	Radiation Therapy	Yes/No	Fainting or Dizzy Spells	Yes/No
Artificial Joints (hip, knee, etc)	Yes/No	Chemotherapy	Yes/No	Nervous/Anxious	Yes/No
Kidney Trouble	Yes/No	Tumours	Yes/No	Psychiatric/Psychological Care	Yes/No

7. Have you lost or gained more than 10 pounds in the past year? Yes/No
8. Do you have or have had any disease, condition, or problems not listed? Yes/No
If yes: please list:
_____
_____

9. Women: Are you Pregnant? Yes/No Months? _____ Nursing? Yes/No
Taking birth control pills? Yes/No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature_____

Date:_____

PATIENT REGISTRATION

Surname: ……. First Name:…….. Title: ……

Date of Birth: …… Gender: Male / Female / Non-binary (please circle)

Home Address: ……

Business Address: ……

Email Address: …….. Home Phone No: ……

Work Phone No: …… Mob Phone No: ……

Occupation: ……..

Emergency Contact No: …… Phone: …….

Address: ……...

Closest Relative not living with you: …….

Phone: ……

Address: ……

Person Responsible for Account: ……..... Phone: ……

Address:……

Relationship to Patient: ……

CONSENT FOR TREATMENT

1. I hereby authorise the dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of (name of patient) ……...'s dental needs.

2. Upon such diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anaesthetics and other medication as necessary. I fully understand that using anaesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf of my dependants. I understand that payment is due at the time to service unless other arrangements have been made. If required I also understand a check of my credit history may be made.

Patient's Signature: ……..……

Date: ……