Nic Belk, DMD
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General Dentistry
321 West Cherokee Street
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601.835.0353
www.belkditcharodental.com

Welcome to your new dental family.

Whom may we thank for referring you? _____

Date _____

Patient's Name _____

If Child: Parent's Name _____

Patient's Preferred Name _____

Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Minor ❒

Sex: M ❒ F ❒

Address _____

City _____ State _____ Zip _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Email _____

Birthdate_____/_____/_____ SSN#_____-_____-_____

Patient/Parent Employed By _____

Employer's Address _____

City _____ State _____ Zip _____

Occupation _____

How long there? _____

Where/when are the best times to reach you? _____

Person Responsible for Account _____

Name of Spouse _____

Birthdate_____/_____/_____ SSN#_____-_____-_____

Spouse Employer _____

Spouse Work Phone _____

Spouse Mobile Phone _____

Dental Insurance Information

Insured's Name _____

Birthdate____/_____/_____ SSN#_____-_____-_____

Employer Name _____

Insurance Company Name _____

Group/Policy Number _____

Patient's Relationship to Insured _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for these activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to Belk Ditcharo Dental of dental insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature

_____

Date_____/_____/_____

PATIENT REGISTRATION

BELKDITCHARO dental

Patient's Name _____ Date of Birth _____/_____/_____

Purpose of Initial Visit _____

Are you aware of any problems? _____

How long since your last dental visit? _____

What was done at that time? _____

Previous dentist's name _____

When was the last time your teeth were cleaned? _____

Please mark the appropriate answer.
If you do not know the correct answer, please write "don't know" on the line after the question.

Have you made regular dental visits? .....YES ❒ .....NO ❒

How often? _____

Were dental x-rays taken? .....YES ❒ .....NO ❒

Have you lost any teeth or have any teeth been removed? .....YES ❒ .....NO ❒

Have they been replaced? .....YES ❒ .....NO ❒

How have they been replaced? (Check all that apply and give age of prosthesis)

- ❒ Fixed Bridge _____
- ❒ Removable Denture _____
- ❒ Complete Denture _____
- ❒ Implant _____

Are you unhappy with the replacement? .....YES ❒ .....NO ❒

If yes, please explain. _____

Have you ever had any problems or complications with previous dental treatment? .....YES ❒ .....NO ❒

If yes, please explain. _____

Do you clinch or grind your teeth? ..... YES ❒ .....NO ❒

Does your jaw click or pop? .....YES ❒ .....NO ❒

Have you experienced any pain or soreness in the muscles of your face or around your ear? ....YES ❒ .....NO ❒

Do you have frequent headaches, neckaches, or shoulder aches? .....YES ❒ ....NO ❒

Does food get caught in your teeth?.....YES ❒ ....NO ❒

Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?

Do your gums bleed or hurt? .....YES ❒ ....NO ❒

When? _____

How often do you brush your teeth? _____

Do you use dental floss? .....YES ❒ ....NO ❒

How often? _____

Are any of your teeth loose, tipped, shifted, or chipped? .....YES ❒ ....NO ❒

Are you unhappy with the appearance of your teeth?.....YES ❒ ....NO ❒

Do you feel your breath is offensive at times? .....YES ❒ ....NO ❒

Have you ever had gum treatment or surgery? .....YES ❒ ....NO ❒

What/Where/When? _____

_____

Have you had any orthodontic work (braces)? _____

Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike? _____

COMMENTS

I certify that the patient information, dental history, and medical history are complete and accurate.

Patient's/Guardian's Signature _____ Date_____/_____/_____

Dentist's Signature _____ Date_____/_____/_____

DENTAL HISTORY

BELKDITCHARO dental

Patient's Name _____ Date of Birth _____/_____/_____

Physician's Name _____

Are you currently under a physician's care? .....YES ❒ .....NO ❒

If yes, please explain. _____

Are you currently taking any medications? .....YES ❒ .....NO ❒

If yes, please list. _____

_____

Are you allergic to any medications? .....YES ❒ .....NO ❒

If yes, please list. _____

_____

Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? .....YES ❒ .....NO ❒

Are you sensitive to any metals or latex? .....YES ❒ .....NO ❒

Do you have any other allergies or hives? .....YES ❒ .....NO ❒

If yes, please list. _____

_____

Have you ever experienced any complication or illness following dental treatment? .....YES ❒ .....NO ❒

If yes, please explain. _____

_____

Do you use tobacco? .....YES ❒ .....NO ❒

If yes, what kind? .....SMOKE ❒ ....SMOKELESS ❒

If yes, frequency of use (packs or cans per day)? _____

_____

Have you ever taken Fosamax, Zometa, Aredia, or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .....YES ❒ .....NO ❒

Women: Are you pregnant or suspect you may be? .....YES ❒ .....NO ❒

Women: If yes, how many weeks pregnant? _____

Women: Do you use any birth control medications? .....YES ❒ .....NO ❒

Women: Are you nursing? .....YES ❒ .....NO ❒

Do you or have you experienced the following? (Circle any that apply.)

Abnormal Bleeding	Fainting Spells	Mitral Valve Prolapse
Alcohol Abuse	Fever Blisters	Pacemaker
Anemia	Glaucoma	Persistent Cough
Arthritis	Hay Fever	Psychiatric Problems
Artificial Joints/Bones	Headaches	Radiation Treatment
Artificial Valves	Heart Attack	Rheumatic Fever
Asthma	Heart Murmur	Scarlet Fever
Blood Transfusion	Heart Surgery	Seizures
Cancer	Hemophilia	Sickle Cell Disease
Chemotherapy	Hepatitis	Sinus Problems
Chicken Pox/Shingles	Herpes	Steroid Therapy
Colitis	High Blood Pressure	Stomach Problems
Congenital Heart Defect	HIV+/AIDS	Stroke
Diabetes	Hospitalization	Thyroid Problems
Difficulty Breathing	Kidney Problems	Tonsillitis
Drug Abuse	Liver Disease	Tuberculosis (TB)
Emphysema	Low Blood Pressure	Ulcers
Epilepsy	Lupus	Venereal Disease

Do you have any disease, condition, or problem not listed? .....YES ❒ ....NO ❒

If yes, please explain. _____

COMMENTS

BLOOD PRESSURE MEASUREMENTS		
Date	Blood Pressure	Initials

MEDICAL HISTORY