Bella Dente
FINE DENTISTRY

13650 W. Colonial Dr. Ste. 120-A, Winter Garden, FL 34787

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ Zip _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security # _____

Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other _____

Email _____ Occupation: _____

In case of emergency, please contact: Name & Phone: _____

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____

Birth date of policy owner _____ Their Social Security # _____

Insurance Co. _____ Phone # _____

Assignment and Release: I certify that I and/or my dependant(s) have insurance coverage with and assign directly to Dr. Dalila Harris all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____

Signature of Patient Date

Dental History

Why have you come to see us today? _____

Do you have specific area(s) causing you discomfort? _____

When was the last time you saw a dentist? _____ Name of previous Dentist? _____

How often do you brush? _____ Floss? _____ Do your gums ever bleed? _____

Is your bite comfortable when biting/chewing? _____ Do you feel that you grind your teeth? _____

Does your jaw hurt/feel tired? _____

Have you had any sores/bumps in or near your mouth? _____ If yes, how often/where? _____

If you could easily and safely whiten your teeth, would you be interested? _____

Do you have any old fillings or dental treatments that you are unhappy with? _____

Are your teeth sensitive to Heat, Cold, Sweets, Biting Pressure? _____ Where? _____

Health History

Date of last health care exam? _____ What was this exam for? _____

Are you currently receiving Care? Yes ☐ No ☐ If yes, the nature of this care:

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Have you been hospitalized in the past 5 years? ☐ Yes ☐ No If yes, reason _____

Have you ever had a serious head or neck injury? _____ If so, please explain _____

Are you currently taking any **medications?** Purpose? Please list _____

Have you ever taken **Phen-fen/Redux**? ☐ Yes ☐ No If yes, have you made your physician aware of your past Use and have you been cleared by and echocardiogram of any heart defects? ☐ Yes ☐ No Comments:

Have you ever been under bisphosphonate therapy, taken orally such as **Actonel** or **Fosamax**, or taken through an IV such as **Aredia** or **Zometa**? ☐ Yes ☐ No If yes, for what condition, for how long and when was your last dose? _____

Do you use Tobacco Products? ☐ Yes ☐ No If yes, what type and how much? _____

For Women Only

Are you pregnant or planning to become pregnant? ☐ Yes ☐ No If yes, due date: _____

Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

Have you ever been premedicated for dental treatment? ☐ Yes ☐ No If yes, why?

Are you **Allergic** to or Have You Had an **Adverse Reaction** to:

☐ Y	☐ N	Latex or rubber products	☐ Y	☐ N	Penicillin	☐ Y	☐ N	Ibuprofen or Aspirin
☐ Y	☐ N	Local anesthetics	☐ Y	☐ N	Iodine	☐ Y	☐ N	Codeine
☐ Y	☐ N	Sedatives	☐ Y	☐ N	Metals	☐ Y	☐ N	Other

Do you have or have you ever had: Answer by checking Yes (Y) or No (N)

☐ Y	☐ N	AIDS,HIV positive	☐ Y	☐ N	Excessive bleeding	☐ Y	☐ N	Lung disease
☐ Y	☐ N	Alzheimer's	☐ Y	☐ N	Excessive thirst	☐ Y	☐ N	Mitral valve prolapse
☐ Y	☐ N	Anaphylaxis	☐ Y	☐ N	Fainting/dizzy spells	☐ Y	☐ N	Pain in jaw joint
☐ Y	☐ N	Anemia	☐ Y	☐ N	Frequent cough	☐ Y	☐ N	Parathyroid disease
☐ Y	☐ N	Angina	☐ Y	☐ N	Frequent diarrhea	☐ Y	☐ N	Psychiatric care
☐ Y	☐ N	Arthritis/Gout	☐ Y	☐ N	Frequent headache	☐ Y	☐ N	Radiation therapy
☐ Y	☐ N	Artificial heart valve	☐ Y	☐ N	Head injury	☐ Y	☐ N	Recent weight loss
☐ Y	☐ N	Artificial joint	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Renal dialysis
☐ Y	☐ N	Asthma	☐ Y	☐ N	Hay fever	☐ Y	☐ N	Rheumatic fever
☐ Y	☐ N	Blood disease	☐ Y	☐ N	Heart attack/failure	☐ Y	☐ N	Rheumatism

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☐ Y	☐ N	Blood transfusion	☐ Y	☐ N	Heart murmur	☐ Y	☐ N	Scarlet fever
☐ Y	☐ N	Breathing problems	☐ Y	☐ N	Heart pace maker	☐ Y	☐ N	Shingles
☐ Y	☐ N	Bruise easily	☐ Y	☐ N	Heart trouble/Dx.	☐ Y	☐ N	Sickle cell disease
☐ Y	☐ N	Cancer	☐ Y	☐ N	hemophilia	☐ Y	☐ N	Sinus trouble
☐ Y	☐ N	Chemotherapy	☐ Y	☐ N	Hepatitis a	☐ Y	☐ N	Spina bifida
☐ Y	☐ N	Chest pains	☐ Y	☐ N	Hepatitis B/C	☐ Y	☐ N	Stomach/intestinal Dx.
☐ Y	☐ N	Cold sores/fever blisters	☐ Y	☐ N	Herpes – oral	☐ Y	☐ N	Stroke
☐ Y	☐ N	Congenital heart disorder	☐ Y	☐ N	High blood pressure	☐ Y	☐ N	Swelling of limbs
☐ Y	☐ N	Convulsions	☐ Y	☐ N	Hives/rash	☐ Y	☐ N	Thyroid disease
☐ Y	☐ N	Cortisone therapy	☐ Y	☐ N	Hypoglycemia	☐ Y	☐ N	Tonsillitis
☐ Y	☐ N	Diabetes Type	☐ Y	☐ N	Irregular heartbeat	☐ Y	☐ N	Tuberculosis
☐ Y	☐ N	Drug dependency	☐ Y	☐ N	Kidney problems	☐ Y	☐ N	Tumors/growths
☐ Y	☐ N	Easily winded	☐ Y	☐ N	Leukemia	☐ Y	☐ N	Ulcers
☐ Y	☐ N	Emphysema	☐ Y	☐ N	Liver disease	☐ Y	☐ N	STD's
☐ Y	☐ N	Epilepsy/seizures	☐ Y	☐ N	Low blood pressure	☐ Y	☐ N	Yellow jaundice

☐ Y ☐ N Other serious illness not listed above, Explain _____

Please list all names and phone numbers of the physicians who are currently providing your care

1. _____
2. _____
3. _____

Authorization and Release

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. If my health or medications change I will inform my doctor at my next appointment

_____ _____

Signed by Patient/Guardian Date