Portia J. Bell D.D.S.

Name:_____

Preferred Name: _____Social Security Number: _____

Referred By: _____

Gender: _____ Marital Status: _____ Date of Birth: _____

Street Address (No P.O. Box): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Your Employer: _____ Work Phone: _____

Primary Dental Ins. Carrier: _____ Phone: _____

Group #: _____ Member ID #: _____

Ins. Subscriber Name: _____ Social Security Number:_____

Ins. Subscriber Date of Birth: _____ Ins. Subscriber Employer: _____

Secondary Dental Ins. Carrier: _____ Phone: _____

Group #: _____ Member ID #: _____

Ins. Subscriber Name: _____ Social Security Number:_____

Ins. Subscriber Date of Birth: _____ Ins. Subscriber Employer: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relation: _____

Dental History

Your current dental health is: Good Fair Poor

Are you currently in pain? Yes No

Have you ever been diagnosed and/or treated for gum disease? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Is there anything you would like to change about your smile? Yes No

Do your gums bleed when brushing or flossing? Yes No

How often do you: Brush_____ Floss_____

Are your teeth sensitive to heat, cold, sweets, or biting pressure? Yes No

Have you lost any teeth? Yes No

Have you ever had an unfavorable dental experience? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

If so, please explain_____

When was your last dental visit? _____ Last dental cleaning? _____

Have you had dental x-rays within the last 12 months? _____

Why did you leave your previous dentist? _____

Here at **PORTIA J. BELL DDS, INC.,** we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Invisalign/Clear Braces	Gum Disease Treatment	Implants	Tooth Whitening
Oral Cancer Screening	Bridges	Sport/Night Guards	Partials/Dentures
Extractions	Smile Makeover	Veneers/Lumineers	Cavity Control
Bonding	Sealants	Snap On Smile	Crowns

Medical History

Have you had hip/knee replacement surgery or any heart surgery in the last two years? _____

If you answered yes, please call your surgeon to inquire if you will need an antibiotic before your dental treatment.

Are you allergic to any of the following? Please Circle.

Penicillin Nuts of Avocado Codeine Aspirin

Sulfa Drugs Latex Amoxicillin

Do you have or have you ever had any of the following? Please Circle.

Rheumatic Fever Heart Condition Any Surgery Kidney Problems

Arthritis High Blood Pressure Sinus Problems/Allergies

Difficulty Opening or Closing Mouth High Cholesterol Diabetes

Anemia Bleeding Problems Asthma Orthodontic Treatment

Digestive System Disorders Tuberculosis HIV/Aids Stroke

Tobacco Use of Any Kind Pain in Jaw Joint/Ear/Side of Face Eye Surgery

Hepatitis A, B, or C Women, are you pregnant

If you have any condition or problem that is not mentioned that you feel we should be aware of, please note it here.

_____

_____

Name and Phone Number of Personal Physician:

_____

Name and Phone Number of Specialty Physician(s):

_____

_____

_____

Current Medications:

Name_____
Dosage_____
Name_____
Dosage_____
Name_____
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Dosage_____

"I understand that the information I have provided on this form is essential to determine my dental needs and to provide proper dental treatment. I understand that if any change in my health occurs, I am to inform this office at my next scheduled appointment so that my medical history can be updated. I understand each question and have answered each of them truthfully and to the best of my ability."

_____

Signature Date

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. Please read and sign below.

*** This office employs licensed, board certified Hygienists who will be integrally involved in your patient care and providing your treatment.**

***Please note, our relationship is with you and not your insurance company or pharmacy.**

***When you receive your reminder call, email, or text, please reply your intent. We require 48 hour notice for cancelation. Failure to give 48 hr advance notice of cancellation will result in a fee of $50.00. If the appointment is not confirmed there is a possibility that the appointment will be given to another patient.**

***Patients are responsible to know their insurance benefits prior to first visit.**

***NSF Check Recovery is fee $50.00**

***Statements are billed once a month.**

***Insurance Billing - We bill the insurance company the same day of service.**

***Patient's are responsible to notify the office of changes in insurance coverage, employment, name, phone numbers, address, etc.**

***Co-payment and Fee for service is due at the time of service.**

***If pre treatment instructions have not been followed, your procedure may be cancelled.**

***Patients under 18 years old must be accompanied by a parent or guardian or have proper documentation completed. Forms are available upon request.**

***Be prepared to share the name, quantities, and frequency of dosage of the medicines you take.**

***Patients coming from another office are responsible for having their records and x-rays transferred to our office prior to their scheduled appointment.**

My signature acknowledges that I have read and I understand the above statements.

Patient Printed Name _____

Patient Signature _____

Date_____

Appointments

When an appointment is scheduled in our office, the time is reserved exclusively for you. We know that you value your time and so do we! Because we do not overbook our time, it is very important for us to receive adequate notice to make the arrangements necessary to utilize that time. We have found that the following considerations provide the best care for all of our patients.

- In order to keep our overhead and your costs as low as possible, we ask that you give us at least 48 hours notice if you are unable to keep an appointment. Cancelled appointments that are unable to be rescheduled because of lack of notice contribute to the rising costs of your dental care.
- Unconfirmed appointments are subject to be cancelled if not confirmed 48 hours prior to treatment.
- We will work with you if you wish to schedule more than one family member at the same time. However, if that appointment needs to be rescheduled and you are not able to provide 48 hours notice we will need to reschedule those appointments separately.
- 9:00 am, 4:00 pm, and 5:00pm appointments are in extremely high demand. If you are unable to keep one of these appointments and are unable to give us notice, we will ask you to reschedule at a different time.
- Broken appointments are very costly. To be fair to all of our patients we will ask you to help with the cost associated with these appointments by collecting a $50 broken appointment fee.
- Please be on time or early for your scheduled appointment, so that other patient appointments are not affected. If you are more than 15minutes late for your appointment you may have to wait to be worked in to the schedule, or we may need to reschedule your appointment entirely.
- If you have an emergency needing immediate attention, we do our best to see you that day. Occasionally these emergencies cause us to run a little behind. If we know that our schedule is compromised, we will make every effort to let you know ahead of time.
- You are welcome to use your cell phones in our reception area but we ask that you please turn cell phones off or on vibrate while in the treatment rooms.
- We have found that it is in the best interest of our patients if family members remain in the reception area during treatment. Thank you for your cooperation.

Please acknowledge your understanding of these statements with your signature below.

_____ _____

Signature **Date**

Patient X-Rays

In accordance with our Healthy Mouth Standard we pride ourselves in delivering the highest quality of care. In order to do so, we complete a Comprehensive Oral Examination (billing code D0150) and a Panoramic X-Ray (billing code D0330) for each new patient and every three years for our patients of record. Some dental insurance companies limit the coverage for these procedures. Our office has decided to stay within the high standard of care guidelines, which indicates that every three years is appropriate. Please acknowledge your understanding of this statement with your signature below.

_____ _____

Signature **Date**

Oral ID

Consent Form - Oral Cancer Screening

Our office strives to bring its patients state -of-the-art technology to provide you with the latest advancements in oral health. The Oral Cancer Screening is now a part of the high standard of care we provide. The Oral ID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre cancer) before they can be detected with the naked eye. The procedure is quick, painless, and there are no rinses used.

Similar to other cancers, early detection of Oral cancer is critical. Studies have shown that early detection of oral cancer with technologies like the Oral ID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk/What are some causes?

*Previous history or family history of cancer

*Persons age 17+ years *Tobacco use *Alcohol use *HPV Infection

If you have any questions about risk factors, please feel free to ask.

Please acknowledge your consent for this examination with your signature below.

_____ _____

Signature **Date**

Portia J. Bell D.D.S

PLEASE READ THROUGHLY AND INITIAL THE HIGHLIGHTED AREAS!

We realize that every persons financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. **WE CANNOT GURANTEE ANY ESTIMATED COVERAGE.** Because the insurance policy is an agreement between you and the insurance company. **YOU** are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy. Insurance is filed the day you receive treatment with the information you provide in this paperwork.

If for some reason your insurance company has not paid their portion within 30 days from the filing of the insurance, **YOU** are responsible for payment at that time. **IT IS YOUR RESPONSIBILITY TO FOLLOW-UP WITH THE INSURANCE COMPANY REGARDING NONPAYMENT ON YOUR CLAIM.**

PAYMENTS DUE UPON TREATMENT

PLEASE INTIAL THE BOXES AND SIGN BELOW

_____ All estimated copayments are due in full at the time of treatment.

_____ For no insurance, payment is expected in full at the time of the treatment. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, LENDING CLUB, and CARE CREDIT

_____ For participating insurances (Those insurances in which this office has agreed to accept that company's payment rates), **the applicable co-payment is to be paid at the time of treatment. This co-payment is only an estimate, your actual patient portion may vary.**

_____ For **non**participating insurances (All other insurances), estimated copayments are due at the time of treatment. We will file Insurance claims as a courtesy to you and wait 30 days for insurance to pay the estimated amount due. You are responsible for the doctors total fee regardless of what insurance pays.

OTHER FEES

_____ **NO SHOWS** - Our office confirms all treatment appointments in advance. This time is set aside just for you. If you do not come to your scheduled appointment time and give a 48 hour notification to our office you will be assessed a $50.00 no show fee. Your insurance will not pay this fee.

_____ **PARTIAL TREATMENT** - If you begin treatment and then chose not to complete treatment, you are still responsible for the appropriate full treatment fee and all subsequent possible oral health complications.

ANY CHECKS RETURNED TO US WILL BE CHAGED $50.00 RETURN CHECK FEE.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE, I HEREBY AUTHORIZE THE ABOVE NAME DENTIST TO FILE DENTAL INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO HIM FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. **I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.**

_____/_____

Signature **Date**

Portia J. Bell D.D.S.

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes: conference presentations, educational presentations, courses informational presentations, on-line educational courses, and educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.

Signature_____ Date_____

If this release is obtained for a patient under the age of 19, then the signature of that parent or legal guardian is also required.

Parent's Signature_____ Date_____

Portia J. Bell D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Print Name

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ other (Please Specify)
- ☐