M. Don Bell, D.M.D.
University of Alabama School of Dentistry (1975)
Advanced Clinical Dentistry Residency
Eglin Air Force Base, Florida (1989)
USAF Colonel (Retired)

Dr. Bell is committed to excellence in dentistry and therefore requires straightforward answers to the following questions in this confidential questionnaire. Superior results begin with clear communication. Please ask if you need any assistance. Thank you.

ABOUT YOU

Name_____ Prefer to be called_____
Last First MI

( ) Single ( ) Married ( )Dependent ( )Other Birth Date____/____/_____ ( ) Male ( ) Female

S.S. #_____-_____-_____ Driver's License_____

Address_____

City_____State_____Zip_____

Home Phone _____ Work_____ Cell_____

Email_____ Occupation_____

Employer_____ How long? _____

Employer Address_____

City_____State_____Zip_____

EMERGENCY CONTACT
Person to contact in case of emergency

Name_____ Relationship _____
Last First MI

Home Phone_____Work_____Cell_____

PERSON RESPONSIBLE FOR PAYMENT

( ) Same as above Name_____
Last First MI

Relationship_____ Birth Date_____/_____/_____ ( ) Male ( ) Female

Billing Address_____

City_____State_____Zip_____

Home Phone_____Work_____Cell_____

S.S. #_____-_____-_____ Driver's License_____

Email_____Occupation_____

Employer_____ How long?_____

SPOUSE INFORMATION

( ) Same as above Name_____
Last First MI

Email_____ Birthdate____/____/_____ ( ) Male ( ) Female

Employer_____ How long?_____

Home Phone_____ Work _____Cell_____

MEDICAL HISTORY

Name of Physician_____Phone_____

Please Check any condition listed below that you have, or have had in the past.

[ ]Allergies/Hay Fever	[ ]Epilepsy/Seizures	[ ]Heart Surgery*	[ ]Rheumatism
[ ]Anemia	[ ]Excessive Thirst	[ ]Hepatitis	[ ]Scarlet Fever
[ ]Angina	[ ]Fainting/Dizziness	[ ]High Blood Pressure	[ ]Sickle Cell Disease
[ ]Arthritis	[ ]Fever Blisters/Cold Sore	[ ]HIV/AIDS	[ ]Sinus Problems
[ ]Artificial Joints*	[ ]Frequent Cough	[ ]Kidney Problems	[ ]Stroke
[ ]Artificial Heart Valves*	[ ]Glaucoma	[ ]Liver Problems	[ ]Surgical Stint*
[ ]Asthma	[ ]Headaches	[ ]Mental Disorders	[ ]Thyroid Problems
[ ]Breathing Problems	[ ]Heart Disorder*	[ ]Mitral Valve Prolapse	[ ]Tuberculosis
[ ]Cancer	[ ]Heart Failure*	[ ]Osteoporosis	[ ]Tumors
[ ]Chemical Dependency	[ ]Heart Infection*	[ ]Radiation Treatment	[ ]Ulcers
[ ]Chemotherapy	[ ]Heart Murmur*	[ ]Respiratory Problems	[ ]Venereal Disease
[ ]Diabetes	[ ]Heart Pace Maker*	[ ]Rheumatic Fever	[ ]Yellow Jaundice

*This condition requires antibiotic pre-medication for certain dental procedures.

If you checked a box for any conditions listed above, please explain: _____

_____

( )Yes ( )No Are you allergic to any medications or substances? If yes, please check box:

( )Aspirin ( )Penicillin ( )Codeine ( )Iodine ( )Metal ( )Latex ( )Other(s)
_____

( )Yes ( )No Have you been admitted to a hospital or have you needed emergency care in the past 2 years? If yes, please explain. _____

( )Yes ( )No Are you taking medications or herbals? If yes, please list:_____

_____

_____

( )Yes ( )No Have you used tobacco? If yes, how much/how long? _____

( )Yes ( )No Have you ever taken a bisphosphonate medication?

Fosamax Actonel Atelvia Didronel Boniva

Please circle any that apply.

( )Yes ( )No Have you ever taken any of the following diet medications?

Dexfenfluramin Fen-phen Pondimin Redux

Please circle any that apply.

( )Yes ( )No Have you ever taken any of the following blood thinners?

Coumadin Warfarin

Please circle any that apply.

( )Yes ( )No Have you ever taken any of the following thyroid medications?

Levoxyl Synthroid

Please circle any that apply.

( )Yes ( )No Is there anything in your body that was not there when you were born? (Implants, etc)
If yes, please explain:_____

_____

_____

If you are a female, please check one of the following which applies to you:

( ) Pregnant ( ) Trying to become pregnant ( )Nursing ( )Taking oral contraceptives ( ) None

If you are child bearing, please state how far along you are in your pregnancy: _____

NOTE: Depending on the current trimester of a child bearing patient, by law, we may or may not be able to perform treatment or take radiographs. (Exceptions made in the event of severe emergencies.)

I certify all the above answers are complete and correct to my knowledge. Any changes in my health status or medications will be disclosed to Dr. Bell or a member of his staff.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

_____

M. Don Bell, D.M.D.

DENTAL HEALTH QUESTIONAIRRE

Dr. Bell believes each patient deserves to know their current level of dental health; the process by which they arrived at same; and most importantly, the treatment options available to attain the desired level of dental health. This process begins with a careful diagnosis and personalized treatment plan. Dr. Bell will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. Appropriate X rays, photographs and/or impressions of your teeth will be taken to further evaluate areas of concern. Dr. Bell will evaluate your diagnostic findings, then discuss your treatment options with you. Your custom treatment plan will then be developed to enable you to achieve your stated goals.

Please check the statement below that best represents the level of dental health you want to achieve.

( ) **Emergent Care Only**
I am interested only in emergency dental care for the relief of pain, and if applicable to resolve an infection.

( ) **Maintenance Care**
I want to address existing dental problems, and I want to take an active part in the prevention of further dental disease. However I acknowledge that maintenance care may not be enough to help me achieve maximum protection and longevity; therefore my dental health may not remain stable over time.

( ) **Comprehensive Care**
I am interested in comprehensive care that resolves the causes of dental disease, not simply the effects. I want to have the best dental care available for maximum protection and longevity.

( ) **Comprehensive and Cosmetic Care**
I want all dental treatment that is the best available for maximum protection, longevity and cosmetic appearance; so as to achieve and maintain long-term, stable and aesthetic dental health.

1) Have you had a full mouth set of X rays within the past 3 years? ( )Yes ( )No

2) I have a ( ) low ( ) moderate ( )great fear of dental treatment.

3) My mouth and teeth are ( ) very ( )moderately ( )not at all comfortable.

4) I am: ( )very satisfied ( )satisfied ( )dissatisfied ( )very dissatisfied with the appearance of my teeth.

5) My present state of dental health is ( )excellent ( )good ( )fair ( )poor.

6) My main concerns with my dental health are:_____
_____
_____.

7) I would like a smile evaluation and treatment plan for enhancing my smile. ( )Yes ( )No

GENERAL CONSENT TO TREATMENT

I agree and consent to a dental examination by Dr. Bell. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to initiation. I agree to abide by Dr. Bell's treatment recommendations. I acknowledge there are no guarantees--expressed or implied, as to the results of any procedures or dental treatments performed.

PHOTOGRAPHY RELEASE

I authorize Dr. Bell and/or a member of his staff to take photographs of me BEFORE and/or AFTER my treatment is completed. I understand these photos may or may not be published on the 5 Star Dentistry website, in office brochures, or any media. I also understand and agree that Dr. Bell is the owner of such photographs.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

M.D. Bell Associates Inc.
M. Don Bell, DMD

Consent for Treatment
Financial Responsibility
Release of Information
Notice of Privacy Practice Acknowledgement

I consent for medical treatment by M. Don Bell, DMD.

I understand that payment is due at the time services are rendered. I authorize M. Don Bell, DMD to release of dental & medical information for insurance claims, and the release of past payment history, if needed. I also understand I am responsible for any non-covered services. I, the undersigned, agree the fees charged are legal and lawful debt. I understand that if my account becomes past due I am responsible for paying collection fees of up to 33.33% and/or attorney fees and court costs.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This act gives you or the parents, significant new rights to understand and control how your health information is used. HIPPA provides penalties for misuse of personal health information. If you wish to review these copies of the (HIPPA) Privacy Practice we will be glad to provide you a copy.
You have the following rights with respect to your health information:

1. The right to access, inspect, and copy your information.
2. The right to request an amendment to your health information.
3. The right to receive an accounting of certain disclosures of your health information.
4. The right to receive confidential communications.
5. The right of request restrictions or disclosures concerning your health information.

****** I hereby consent that medical information and treatment can be discussed with the following person or persons. If you want this information only discussed with you leave the following blank. An example would be spouse, parents, etc.

_____ _____

****** I hereby consent that appointment reminders can be left on answering machine or with family members. ____ (Initial) (HM#) _____ (WK#) _____ or (CELL#) _____

_____ _____
Date Signature

M.D. Bell Associates, Inc. Office Policies

Please read and initial beside the following office policies:

We will collect payments at the time services are rendered. Any exceptions to this policy or other arrangements must be approved by the office manager, in writing, prior to appt. day.

Initials: _____

Appointments that are not cancelled or rescheduled prior to 24 hours before the appointment time will be charged a broken appointment fee.
Fees will be based on the time allotted and procedure being performed.
Minimum fee will be $50.00. Initials: _____

Children **MUST** have adult supervision in the waiting room at all times. **Minor children are not allowed in the treatment rooms unless they are receiving treatment as a patient.**

Initials: _____

I have read and understand the statements as presented above.

_____ _____
Signature of Patient/ Guardian Date

_____
Printed name of Patient