Bethel DENTAL
The smile starts here
NO 49 OSU BADU STREET DZORWULU ACCRA GHANA.
(233) 0302-771155 / 0302-771156

Patient Name _____ _____
First Middle Last Title Preferred Name

Address _____

City_____ Region_____ Ghana Post Address_____

Home Phone _____ Mobile Phone _____ Email _____

Gender ☐ Male ☐ Female Birthday (Month/Day/Year) _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or parent's employer _____ Work phone _____

Business address/ Branch _____ City _____

Person to contact in case of an emergency _____ Phone _____

How did you hear of us? ☐ Internet ☐ Facebook/Twitter ☐ Dental Education Session ☐ Referred by_____

Who will be paying your bill? …. Self ….Other

Responsible Party

i. Individual Responsible for paying bill _____ Relationship to Patient _____
Name

Address_____ Phone_____
Email Address _____
Employer_____ Work Phone_____
Is this person currently a patient in our clinic? Yes No

ii. My Employer is responsible for paying my bill: Company Information

Name of Employer: ……..
Address……..
Telephone Number…….
Branch……
Staff ID Number:……..

iii. **My Insurance is responsible for paying my bill** .

Name of Insurance Company.---------- Name of Insured_____
Relationship of Insured to patient_____
Birthday_____ Insurance Card #_____
Name of employer_____ Work Phone_____
Employer address/ Branch _____ City_____

X _____

Signture of patient (or parent, if minor)

Date_____

Medical History

Please tick Yes or No (If Yes, please fill in details)

- ☐ Yes ☐ No Are you taking any medication? _____
- ☐ Yes ☐ No Are you allergic to any medication? _____
- ☐ Yes ☐ No Do you have a history of a major illness? _____
- ☐ Yes ☐ No Have you had any operations? _____
- ☐ Yes ☐ No Have you ever been involved in a serious accident? _____
- ☐ Yes ☐ No Have you seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthitis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Dental History

What concerns you most about your teeth? _____

When did you last visit a dentist? _____

What was done at the time? _____

- ☐ Yes ☐ No Are you presently in any dental pain? _____
- ☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? _____
- ☐ Yes ☐ No Have you ever lost or chipped any teeth? _____
- ☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? _____
- ☐ Yes ☐ No Is any part of your mouth sensitive to temperature? Where? _____
- ☐ Yes ☐ No Is any part of your mouth sensitive to pressure? Where? _____
- ☐ Yes ☐ No Do your gums bleed when you brush or floss? _____
- ☐ Yes ☐ No Do you have any type of thumb or tongue habit? _____
- ☐ Yes ☐ No Are you a mouth breather? _____
- ☐ Yes ☐ No Are you concerned about bad breath? _____
- ☐ Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? _____
- ☐ Yes ☐ No Are you aware of your jaw clicking or popping? _____
- ☐ Yes ☐ No Have you ever been told that you grind your teeth? _____

☐ Yes ☐ No Do you have “tension” headaches? _____

☐ Yes ☐ No Have you ever experienced chronic ringing in your ears? _____

☐ Yes ☐ No Please list some hobbies or interests _____

Female Patients only:

☐ Yes ☐ No Are you taking any oral contraceptives? _____

☐ Yes ☐ No Are you pregnant? _____

☐ Yes ☐ No Are you nursing? _____

Additional Comments

Is there anything else that you would like the dentist to know? _____

Signature: _____Date: _____