

Patient Information

Patient name: _____ Date: _____
 Social Security # _____ D/O/B _____ M F
 Home phone: _____ Work phone: _____ Cell Phone: _____
 Email: _____
 Address: _____

Street _____ City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Whom may we thank for referring you to our practice?
 Name _____ Relationship _____ Home Phone _____ Work/Cell Phone _____

Medical History

Are you currently under a physician's care? Yes No
 If so, for what reason? _____

Physician's information _____

Name _____ Address _____ City/State/Zip _____ Phone _____

Please mark any of the following you may have had, or have at present:

Rheumatic Fever	Artificial Joints	Epilepsy or seizure	FOR WOMEN:
Heart Murmur	Surgical prosthesis	Fainting or dizzy spells	Are you pregnant?
Congenital Heart Disease	Ulcers	Psychiatric treatment	Yes No
Artificial Heart Valve	Cancer	Osteoporosis	Are you nursing?
Pacemaker	Kidney trouble	Bruise easily	Yes No
High/Low Blood Pressure	Diabetes	Asthma	Do you take birth control?
Heart attack or heart disease	Glaucoma	Hay Fever	Yes No
Blood thinning treatment	Scarlet Fever	Emphysema	
HIV or AIDS	Thyroid Disease	Allergies or Hives	
Hepatitis or liver disease	Tuberculosis	Sinus trouble	
Venereal Disease	Arthritis	Cold sores or herpes	
Inner Ear Disorders or surgery	Stroke	Other	

Do you or have you used? Tobacco? Yes No Alcohol? Yes No Illegal Drugs? Yes No

Have you ever been prescribed to take antibiotics or other medications prior to a dental appointment? Yes No
 Is there anything we should know about your health not covered on this form? Yes No

Please list all medications and dietary supplements you have taken in the past 3 months. Include dosage and reason for taking the medication.

Please mark all medications or health care related substance to which you have experienced an allergic or adverse reaction:

Penicillin _____ Sulfa drugs _____ Other _____
 Codeine _____ Epinephrine _____
 Latex _____ Local Anesthetics _____ None _____

I certify that the above medical information is complete and accurate. _____ **Date** _____

Signature of patient, parent or guardian

DENTAL HISTORY

Reason for seeking dental treatment at this time:

Date of last dental x-rays? _____

Date of last dental visit? _____

Do you or have you ever had any of the following?

Periodontal/gum disease	Loose teeth	Areas of food traps	Unfavorable experience
Perio cleanings or treatment	Cold sores	Difficulty opening wide	Broken teeth
Sensitive or bleedings gums	Bad breath	Clicking or popping of jaw	Dry mouth
Grinding or clenching	Swollen glands	Jaw pain	Growths or lesions in mouth
Swelling or lumps in the mouth	Aching or sensitive teeth	Orthodontic treatment	Other

If you could change your smile, what would you change?

Would you like to speak to the doctor privately about any matter? Yes No

Responsible Party Information

The following information is for: patient's spouse patient's guardian if a minor the person responsible for account

Name _____
 Social Security # _____ D/O/B _____
 Employer: _____ Occupation: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____
 Address: _____
 Street _____ City _____ State _____ Zip _____

Insurance Information

Primary Dental Insurance

Insurance Plan Name and Address: _____

Group #: _____

Insurance Company Phone Number: _____

Electronic Payor ID : _____

Name of Subscriber: _____ D/O/B _____

Subscribers Address: _____

Street City State Zip
 Subscribers Employers Name: _____ Employer Phone: _____
 Employer Address: _____
 Street City State Zip
 Patients relationship to subscriber _____

Secondary Dental Insurance

Insurance Plan Name and Address: _____
 Group #: _____
 Insurance Company Phone Number: _____
 Electronic Payor ID : _____
 Name of Subscriber: _____ D/O/B _____
 Subscribers Address: _____
 Street City State Zip
 Subscribers Employers Name: _____ Employer Phone: _____
 Employer Address: _____
 Street City State Zip
 Patient's relationship to subscriber _____

CONSENT

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs.
 I authorize the release of any information to my insurance company, consulting professionals or others that may request my records.
 I certify that the above insurance information, if applicable, is correct and current. I am aware that it is my responsibility to read and understand my own dental policy. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Dr. Bowman's office. I also understand that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service. I understand my portion may be more if my insurance company does not pay the anticipated amount.
 I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage.

_____ Relationship to Patient _____
 Signature of patient, parent, guardian or responsible party