TRUSTED
DENTAL CENTER
BY BOWTIE DENTAL

Today's Date: ___________________

How did you hear about our office? ____

Name: ____

Last First MI Mr. Mrs. Ms. Dr.

Nickname: ___________________ Date of Birth: ___ /___ /___ SS#: ___ -___ -____

Address: _________________________ City: _______________ State: ____ Zip: _______

HM#: (___) ___ -____ Cell#: (___) ___ -____ WK#: (___) ___ -____ ext. ____

E-Mail Address: ____

DL#: ________________________________ Marital Status: _______________________

Employer Name & Address: ____

Previous/Present Dentist: ____

Person Responsible for Account: ____

PRIMARY DENTAL INSURANCE

Insurance Company Name & Address: ____

Insurance Company Phone#: ________________________ Group#: _______________

Insured's Name: ________________Insured's DOB: __/__ /___ Insured's ID#: __________

Insured's Employer Name & Address: ____

SECONDARY DENTAL INSURANCE

Insurance Company Name & Address: ____

Insurance Company Phone#: ________________________ Group#: _______________

Insured's Name: ________________Insured's DOB: __/__ /___ Insured's ID#: __________

Insured's Employer Name & Address: ____

____ ______________________________

Patient/Guardian Signature Date

MEDICAL HISTORY

PATIENT NAME ____________________________________ BIRTH DATE _____________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	Yes	No	If yes, please explain: ________________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ________________
Have your ever had a serious head or neck injury?	Yes	No	If yes, please explain: ________________
Are you taking any medications, pills or drugs?	Yes	No	If yes, please explain: ________________
Do you take, or have you taken Phen-Fen or Redux?	Yes	No	If yes, please explain: ________________
Have you ever taken Fosamax, Boniva, Actonel or any? Other medications containing bisphospaonates?	Yes	No	If yes, please explain: ________________
Are you on a special diet?	Yes	No	If yes, please explain: ________________
Do you use tobacco?	Yes	No	If yes, please explain: ________________
Do you use controlled substances?	Yes	No	If yes, please explain: ________________

Women:		
Are you pregnant or trying to get pregnant?	Yes	No
Taking oral contraceptives?	Yes	No
Nursing?	Yes	No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other If yes, please explain:
____

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spinal Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapsed	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No
____

Comments:
____
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________________________ DATE ____________________

FINANCIAL POLICY

Cash patients are expected to pay in cash check, or credit card the day the service is rendered, unless specific arrangements are made in advance.

For those patients covered by insurance, we will accept assignment of benefits. This means you must sign the portion of your insurance that assigns payment to our office. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be responsible to pay the deductible, if any, and your portion of the charges the day the service is rendered. We will estimate, as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an ESTIMATE. We will assist you in dealing with the insurance company, but ultimately the responsibility lies with you. If, after 45 days, the insurance company hasn't paid, the paid balance will be due, in full, by you.

No Show/Cancellation Policy: If you fail/no show for your appointment, there will be a 75.00 dollar fee applied to your account. A 48 hour notice is required when canceling your appointment. If you are canceling less than 48 hours, a 75.00 dollar fee will be applied to account.

If you have any questions, feel free to ask them at any time. We wish to be of assistance in any way we can.

Patient/Guardian Signature___________________________________ Date ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES
*You May Refuse To Sign This Acknowledgement

I have received a copy of this offices Notice of Privacy Practices.

Please 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

Communication barriers prohibited obtaining acknowledgement

Other (Please Specify)

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