

Patient Information

Date _____ SSN _____
 Patient _____
 Address _____
 City _____
 State _____ Zip _____
 Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Occupation _____
 Patient Employer _____
 Employer Phone _____
 Spouse's Name _____
 Birth Date _____ SSN _____
 Spouse's Employer _____

Phone Numbers

Home (____) _____
 Work (____) _____
 Cell (____) _____
 Receive Text Messages? Yes No
 Cell Phone Carrier _____
 Email _____

Dental Insurance

Who is responsible for this account? _____
 Relationship to patient _____
 Insurance Co. _____
 ID # _____
 Subscriber's Name _____
 Birthdate _____ SSN _____
 Additional Dental Insurance? Yes No
 Insurance Co. _____
 Group # _____

Assignment and Release

I Certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly

Name of Insurance Company(ies)
 to Dr. Chip and/or Dr. Stephanie Dowell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature _____

Emergency Contact Information

Emergency Contact _____ (Specify someone who does not live in your household)
 Relationship _____ Home (____) _____ Work (____) _____

General Consent

I _____ (print name) give Dowell Family Dentistry my consent to use/disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, for collection proceedings and for health care operations like quality reviews.

I understand that payment is due in full unless other arrangements have been made prior to treatment.

I have been informed that I may review the Notice of Privacy Practices prior to signing this consent.

I understand that this practice has the right to change its privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request.

Any request to revoke this consent after signing must be made in writing.

Signature _____ Date _____

(Patient, parent or legal guardian)

Health History

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough, Persistent/bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes – (Type 1 or Type 2?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis – (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor on head/neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Women Only:			Are you being treated for osteoporosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due Date _____	Have you recently been in the hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Taking birth control pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Have you taken antibiotics before dental appts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Why? _____		

Dental History

Reason for today's Visit <input type="checkbox"/> Check-Up <input type="checkbox"/> Toothache <input type="checkbox"/> Fillings <input type="checkbox"/> Other _____					
Former Dentist _____		Date of last visit _____		Last Dental X-rays _____	
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sore teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw pain/swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bad Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Periodontal Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthodontic/Braces	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you happy with your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you interested in cosmetic dentistry? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Medications - Please list all current medications

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other(s) _____
<input type="checkbox"/> Latex	_____

To my knowledge the above medical information is correct and I will inform this practice of any changes that occur in the future.

Signature _____ Date _____

Authorization and Release (optional)

I _____ hereby authorize Dowell Family Dentistry to take photographs of my face, jaws and teeth. I understand that these photographs may be used in educational lectures, demonstrations, communication with labs, advertising and professional publications. I understand that if any of my photographs are used for publications or demonstrations that my name and other identifying information will remain confidential. I do not expect any compensation, financial or otherwise, for use of these photographs.

Signature _____ Date _____

