Bowman
FAMILY DENTAL

Welcome to Bowman Family Dental

The staff of Bowman Family Dental is honored to provide dental care for you and your family. So that we can serve you better, please complete both sides of this new patient history form.

PATIENT INFORMATION

Patient's Name_____ Today's Date_____
How do you wish to be addressed?_____ Cell Phone_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Birth date_____ Social Security #_____
If patient is a minor, give parent's or guardian's name_____
Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY/BILLING INFORMATION

Name_____
Address_____ City _____ State_____ Zip_____
Mailing address (if different than above)_____
How long at this address_____ Home Phone_____ Work Phone_____ Ext___
Previous address (if less than 3 years)_____ How long at this address?_____
Social Security #_____ Birth date_____ Relationship to Patient_____
Employer_____ Occupation_____ No. Years Employed_____
Spouse's Name_____ Birth date_____ SS#_____
Employer_____ Occupation_____ Years Employed____ Work Phone_____

INSURANCE INFORMATION

Insured's Name_____ Birth date_____ Insured's Soc. Sec. #_____
Insurance Company_____ Group No._____ Local No._____
Insurance Co. Address_____
Do you have dual coverage_____ Yes_____ No If yes: _____
Insured's Name_____ Birth date_____ Insured's Soc. Sec. #_____
Insurance Company_____ Group No._____ Local No._____
Insurance Co. Address_____
Insured's Employer_____

CONSENT FOR TREATMENT

I hereby authorize Bowman Family Dental to administer any treatment and to administer such x-rays, anesthetic, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to Bowman Family Dental.

Date:_____ Signature (patient or parent for minor)_____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time, financial arrangements will be made before treatment is rendered.

Preferred method of payment:_____Cash____Check____Visa/MasterCard____Debit

Medical History

Physician's Name:_____ Phone #:_____
How would you describe your health?_____ Date of last physical_____
Have you been hospitalized in the last 2 years?_____ For?_____
Please list all medications and drugs you are taking:_____

_____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle if allergic)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novocain	Nitrous Oxide	Latex
Codeine	Iodine	Tetracycline	Erythromycin	Xylocaine	Other:_____	

Have you ever had any of the following: (Please circle all that apply)

Heart Trouble	Dizziness or fainting	Hepatitis (type:)	HIV-AIDS-ARC
High/Low Blood pressure	Diabetes	Cancer	Venereal Disease
Heart Attack or Stroke	Kidney or Liver Disease	Tumor or Growth	Cold Sores
Heart Murmur	Ulcers or G.I. problems	X-ray/Chemo Therapy	Fever Blisters
Rheumatic Fever	Thyroid problems	Arthritis or Gout	Herpes
Congenital Heart problems	Asthma or Allergies	Jaw Joint Pain	Bruise easily
Heart Valve or Pacemaker	Sinus Problems	Glaucoma	Frequent Thirst
Bleeding problems or Anemia	Emphysema	Epilepsy or Seizures	Freq. Urination
Blood Disease	Lung Disease	Hypoglycemia	Use Tobacco
Blood Transfusion	Tuberculosis	Drug/Alcohol Addiction	Now Pregnant
Artificial Joint	Psychiatric Care	Eating Disorder	

Do you have any condition or problems not listed above which we should know about?_____
Please explain:_____

Med. Update / /	Update / /	Update / /	Update / /
Changes:_____	Changes:_____	Changes:_____	Changes:_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental History

What are you present dental concerns?_____
When did you last see a dentist?_____ When did you last have dental X-ray?_____
Have you avoided regular dental care?____Yes____No Why?_____
Do you feel you have active decay?___Yes___No Do you fee you have gum diseases?____Yes___No
Have you ever had any periodontal (gum) treatments?____Yes___No
How often do you brush?_____ Floss?_____ Use other cleaning aids?_____
Are you happy with the appearance of you teeth?___Yes___No
Would you like your teeth to be whiter?____Yes___No
What are your dental expectations?_____
Previous dentist?_____ City:_____ State:_____
Would you like us to request your records from your previous dentist:___Yes___No
Date of last dental cleaning?_____
My previous dental experience has been:____positive____neutral____negative

Emergency Information

Name of nearest relative not living with you:_____
Complete Address:_____ City:_____ State:_____ Zip:_____
Phone#:_____