



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#: _____