BOWMAN R. BROWNE, D.D.S.

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

SECTION A ABOUT YOU

Today's Date: _____

Name: _____
Last First MI

E-Mail Address: _____

Birthdate:___/___/____ SS#:_____-_____-_____

☐ Male ☐ Female Marital Status: **S M D W**

Address:_____

_____
City State Zip

Home #:_____ Cell #:_____

Work #: _____ Ext: _____

Occupation:_____

Where and when are the best times to reach you?

Please Circle: Hm Wk Cell **and** AM Afternoon PM

Whom may we thank for referring you?

_____

Previous / Present Dentist:_____
(Please Circle)

Last Visit Date: _____

Emergency Contact:_____

Home #: _____ Cell #: _____

Relationship: _____

Person Responsible for Account:_____

Relation to subscriber: _____

Home #: _____ Cell #: _____

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group Name and #: _____

Subscriber's Name: _____

Subscriber's Birthdate:____/____/____ ID#: _____

SECTION B MEDICAL HISTORY

Do you have a physician? ☐Yes ☐ No

Physician's Name: _____

Phone #: _____Date of last visit:_____

Are you currently under the care of a physician? ☐Yes ☐ No

Please explain:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

SECTION B MEDICAL HISTORY CONT.

Have you ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV / AIDS
Y	N	Arthritis	Y	N	Hospitalized
Y	N	Artificial Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer /Chemotherapy	Y	N	Lupus
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Organ Transplant
Y	N	Difficulty Breathing	Y	N	Pacemaker
Y	N	Emphysema / COPD	Y	N	Psychiatric Problems
Y	N	Epilepsy / Seizures	Y	N	Radiation Treatment
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease
Y	N	Hepatitis	Y	N	Joint Replacement

Please list any serious medical conditions you have ever had:

_____

_____

Please list all medications / foods / materials you are allergic to: _____

Do you smoke or use any other form of tobacco? ☐Yes☐No

Do you have any metal rods, pins, or implants? ☐Yes☐No

Are you taking any prescription/over-the-counter medications? ☐Yes☐No

Please list each one: _____

_____

_____

Do you require antibiotics (premedication) before dental treatment? ☐Yes☐No

Do you have a need for any of the following? ☐Yes☐No

☐ Epi Pen ☐ Nitroglycerin ☐ Rescue Inhaler

Have you ever taken Phen-Fen, Redox, Fosamax or Actonel? ☐Yes☐No

If so, when? _____

For Women: Are you pregnant? ☐Yes☐ No Week #:_____

Are you nursing? ☐Yes ☐ No

SECTION C DENTAL HISTORY

Why have you come to the dentist today?

_____

Are you currently in pain? ☐Yes☐No

If so, where? _____

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you or a family member have a history of gum disease? ☐Yes☐No

How many times a day do you brush? _____

How many times a week do you floss? _____

Are your teeth sensitive to hot, cold, or anything else? ☐Yes☐No

SECTION D PRIVACY & FINANCIAL INFORMATION

Patients who are not covered by insurance are expected to pay by cash, check, or credit card at the time services are rendered.

For those patients who are covered by insurance we will accept assignment of benefits. This means you agree to:

I. Authorize this office to release any information necessary to expedite claims.
II. Authorize this office to bill your insurance company for services rendered.
III. Authorize payment directly to this office of any insurance benefits otherwise payable to you.
IV. Endorse any payments you receive from your insurance over to this office for services rendered.

Insurance deductibles and co-payments are expected the day services are rendered.

There is a $25.00 charge on all returned checks.

This office requires a **24-hour notice** for cancelled appointments. Patients who fail to show for or cancel their appointments without proper notice will be charged a fee of $50.00.

A photocopy of this authorization shall be considered as effective and valid as the original.

SECTION D FINANCIAL INFORMATION CONT.

As a courtesy to you, our office will file your insurance and assist you in getting the most from your benefits. Since benefits vary among insurance carriers, we can only estimate your coverage; therefore, the ultimate responsibility lies with you. After sixty (60) days the balance will be due in full from you. Account balances 120 days past due will receive a 1.5%/month service charge which will be calculated on the 27th of each month based on the present balance.

If patient/guarantor defaults as to any terms of this agreement and this account is referred to an attorney for collection then the patient/guarantor will pay all collection costs including attorney's fees of 33 ⅓% of the principal amount due and owed when turned over for collection and does further agree to pay interest on the unpaid balance from the date that said monies became due and payable.

I understand the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I have been informed of my dental provider's Notice of Privacy Practices. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy.

I consent to any blood test required if the staff obtains an injury from a contaminated needle or instrument during my treatment.

Your signature below indicates you understand and agree to the above policies.

_____

Signature Date

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date:___/___/___

Doctor's Comments : _____

_____

MEDICAL HISTORY UPDATE

I have reviewed my medical history dated ___/___/20___ . _____

Signature Date

I have reviewed my medical history dated ___/___/20___ . _____

Signature Date

I have reviewed my medical history dated ___/___/20___ . _____

Signature Date