Dowell Dentistry

comprehensive & aesthetic care

Name: _____

Last First Middle

Address: _____

Street City State Zip

Cell Phone: _____ Work Phone: _____ Home Phone: _____

E-mail Address:_____ Date of Birth: _____S.S. #: _____

Marital Status: Single Married Other Employer:_____

Spouse's Name: _____ Spouse's Cell Phone: _____

Emergency Contact Information: _____

Name Phone Number

Whom may we thank for referring you to our office? _____

When was your last dental cleaning? _____

What are your long term plans for your dental health? _____

Financial Policy

Our office will do everything possible to help you understand and make the most of your dental insurance benefits. We realize that dental insurance is complex and that is why we provide full assistance to you. Our office will complete and submit dental insurance claims to achieve the maximum reimbursement to which you are entitled. Please be aware that dental insurance is a contract between your employer and the insurance company, not our office. The benefits that you will receive are based on the terms of that contract. You are responsible for the financial portion the insurance company does not cover.

Please be aware that a $25 cancellation fee will apply if you are unable to give 24 hours' notice when changing an appointment.

I understand that I am financially responsible for the dental fee, with or without insurance payment. I hereby authorize release of information requested by the insurance company as it pertains to my dental care. I authorize payment of benefits directly to the provider of service.

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION (Primary)

Name of Insurance: _____
Insured's Name: _____
Insured's Employer: _____
Insured's D.O.B.: _____
Insured's S.S. #: _____
I.D. #: _____Group #: _____

DENTAL INSURANCE INFORMATION (Secondary)

Name of Insurance: _____
Insured's Name: _____
Insured's Employer: _____
Insured's D.O.B.: _____
Insured's S.S. #: _____
I.D. #: _____Group #: _____

MEDICAL HISTORY

Please circle any of the following that apply:

AIDS	Dizziness	HIV Positive	Scarlet Fever
Allergies (Seasonal)	Drug Addiction	HPV	Seizures
Anemia	Emphysema	Jaundice	Sinus Problems
Angina (Chest pain)	Epilepsy	Jaw Joint Pain	Sleep Apnea
Arthritis	Excessive Bleeding	Kidney Disease	Stomach Problems
Artificial Heart Valve	Fainting	Liver Disease	Stroke
Artificial Joint(s)	Glaucoma	Low Blood Pressure	Thyroid Disease
Asthma	Heart Conditions	Mitral Valve Prolapse	Tuberculosis
Bisphosphonate Therapy	Heart Lesions (Congenital)	Nervousness/Anxiety	Ulcers
Blood Disease	Heart Murmur	Pacemaker	Venereal Disease
Cancer	Heart Surgery	Pregnant (Currently)	Other: _____
Chemotherapy	Hepatitis A	Radiation (Head/Neck)	_____
Cortisone Medication	Hepatitis B	Respiratory Problems	_____
Depression	Hepatitis C	Rheumatic Fever	
Diabetes	High Blood Pressure	Rheumatism	

Do any of your immediate family members have heart disease, diabetes, history of a stroke, or other inflammatory diseases?

_____

Are you currently under a physician's care? If so, please provide his/her name & phone number and reason for care.

_____

What medications are you currently taking? Do you take any over the counter medications including aspirin, vitamins/supplements?

_____

Are you currently taking any hormone replacements (i.e. Estrogen, Testosterone, Etc)?

_____

Do you have any allergies to any medications, latex or metals? If so, please list.

_____

Have you taken a bisphosphonate drug (Fosamax)? Y N

Have you been hospitalized in the past year?

_____

INFORMED CONSENT

I certify that the answers to the health questions provided are correct. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify the doctor of any changes at any subsequent appointment. I give my consent for dental treatment the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I also agree to the use of a local anesthetic, as needed.

HIPAA Compliance Patient Consent Form

This notice describes how medical information about you may be used and disclosed in our office. Please review it carefully.

Our Obligations: We are required by law to…

Maintain the privacy of your protected health information

Give you this notice of our legal duties and privacy practices

Follow the terms of this notice

How we May Use and Disclose Health Information:

For Treatment: We may use and disclose your health information to coordinate your dental treatment. For example, we are able to share x-rays and other health information with doctors and medical/dental staff outside our office to provide treatment.

For Payment: We may use and disclose your health information to bill and receive payment from you, from your insurance company, or a third party for the treatment or services you received. For Example, we are able to share clinical notes, x-rays, or any other information needed to receive payment from your insurance provider. When appropriate, we may share billing information with individuals involved in payment for your care.

Your Written Authorization is Required for Other Uses and Disclosures

May we call, email, or send you a text to confirm appointments?	YES	NO
May we leave a voicemail message on the phone number provided?	YES	NO
May we discuss your care with any member of your family?	YES	NO

If YES, please name the person(s) we have permission to talk to:

_____

_____

_____

Patient or Guardian Signature Date