Gentle Caring Dentistry *Douglas Bowman D.D.S., M.S.* **www.gentlecaringdental.com**

Patient Information

Patient name: _____ Date: _____
Social Security # _____ D/O/B _____ M F
Home phone: _____Work phone: _____Cell Phone: _____
Email: _____
Address: _____
Street City State Zip
Employer: _____ Occupation:_____
Emergency Contact: _____
Name Relationship Home Phone Work/Cell Phone
Whom may we thank for referring you to our practice?_____

Medical History

Are you currently under a physician's care? ☐ Yes ☐ No
If so, for what reason? _____
Physician's information _____
Name Address City/State/Zip Phone

Please mark any of the following you may have had, or have at present:

☐ Rheumatic Fever	☐ Artificial Joints	☐ Epilepsy or seizure	**FOR WOMEN**:
☐ Heart Murmur	☐ Surgical prosthesis	☐ Fainting or dizzy spells	Are you pregnant?
☐ Congenital Heart Disease	☐ Ulcers	☐ Psychiatric treatment	☐ Yes ☐ No
☐ Artificial Heart Valve	☐ Cancer	☐ Osteoporosis	Are you nursing?
☐ Pacemaker	☐ Kidney trouble	☐ Bruise easily	☐ Yes ☐ No
☐ High/Low Blood Pressure	☐ Diabetes	☐ Asthma	Do you take birth control?
☐ Heart attack or heart disease	☐ Glaucoma	☐ Hay Fever	☐ Yes ☐ No
☐ Blood thinning treatment	☐ Scarlet Fever	☐ Emphysema	
☐ HIV or AIDS	☐ Thyroid Disease	☐ Allergies or Hives	
☐ Hepatitis or liver disease	☐ Tuberculosis	☐ Sinus trouble	
☐ Venereal Disease	☐ Arthritis	☐ Cold sores or herpes	
☐ Inner Ear Disorders or surgery	☐ Stroke	☐ Other	

Do you or have you used? Tobacco? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No Illegal Drugs? ☐ Yes ☐ No

Have you ever been prescribed to take antibiotics or other medications prior to a dental appointment? ☐ Yes ☐ No
Is there anything we should know about your health not covered on this form? ☐ Yes ☐ No

Please list all medications and dietary supplements you have taken in the past 3 months. Include dosage and reason for taking the medication.
_____

Please mark all medications or health care related substance to which you have experienced an allergic or adverse reaction:

☐ Penicillin	☐ Sulfa drugs	☐ Other _____-
☐ Codeine	☐ Epinephrine	
☐ Latex	☐ Local Anesthetics	☐ None

I certify that the above medical information is complete and accurate.
_____ **Date** _____
Signature of patient, parent or guardian

DENTAL HISTORY

Reason for seeking dental treatment at this time:
_____
Date of last dental x-rays? _____
Date of last dental visit? _____

Do you or have you ever had any of the following?

☐ Periodontal/gum disease	☐ Loose teeth	☐ Areas of food traps	☐ Unfavorable experience	
☐ Perio cleanings or treatment	☐ Cold sores	☐ Difficulty opening wide	☐ Broken teeth	
☐ Sensitive or bleedings gums	☐ Bad breath	☐ Clicking or popping of jaw	☐ Dry mouth	
☐ Grinding or clenching	☐ Swollen glands	☐ Jaw pain	☐ Growths or lesions in mouth	
☐ Swelling or lumps in the mouth	☐ Aching or sensitive teeth	☐ Orthodontic treatment	☐ Other	

If you could change your smile, what would you change?
_____

Would you like to speak to the doctor privately about any matter? ☐ Yes ☐ No

Responsible Party Information

The following information is for: ☐ patient's spouse ☐ patient's guardian if a minor ☐ the person responsible for account

Name _____
Social Security # _____D/O/B _____
Employer: _____ Occupation: _____
Home Phone: _____Work Phone: _____
Cell Phone: _____
Address: _____
Street City State Zip

Insurance Information

Primary Dental Insurance
Insurance Plan Name and Address: _____
Group #: _____
Insurance Company Phone Number:_____
Electronic Payor ID : _____
Name of Subscriber: _____ D/O/B _____
Subscribers Address: _____

Street City State Zip
Subscribers Employers Name: _____Employer Phone: _____
Employer Address: _____
Street City State Zip
Patients relationship to subscriber _____

Secondary Dental Insurance
Insurance Plan Name and Address: _____
Group #: _____
Insurance Company Phone Number:_____
Electronic Payor ID : _____
Name of Subscriber: _____ D/O/B _____
Subscribers Address: _____
Street City State Zip
Subscribers Employers Name: _____Employer Phone: _____
Employer Address: _____
Street City State Zip
Patient's relationship to subscriber _____

CONSENT

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs.
I authorize the release of any information to my insurance company, consulting professionals or others that may request my records.
I certify that the above insurance information, if applicable, is correct and current. I am aware that it is my responsibility to read and understand my own dental policy. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Dr. Bowman's office. I also understand that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service. I understand my portion may be more if my insurance company does not pay the anticipated amount.
I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage.

_____ Relationship to Patient_____
Signature of patient, parent, guardian or responsible party