



DOWELL DENTAL GROUP  
General - Restorative - Cosmetic

www.dowelldental.com

**PERSONAL/DEMOGRPAHIC INFORMATION:**

Patient Name (First and Last): \_\_\_\_\_ Sex (Circle one): Male/Female  
Date of Birth (DOB): \_\_\_\_\_ Marital Status (Circle one): Single/Mar/Div/Sep/Wid  
Social Security Number: \_\_\_\_\_ Home Phone No: \_\_\_\_\_  
Mobile Phone No: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Referred By: Family/Friend/Social Media/Newspaper/Close to Home/Work  
If applicable, who referred you to our office office? \_\_\_\_\_

**INSURANCE INFORMATION:**

Responsibile Party for Bill: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address (If different): \_\_\_\_\_  
Are you covered by DENTAL insurance? (Circle one): Yes / No (If yes, please complete below)  
Insurance Company: \_\_\_\_\_ Subscribers Name: \_\_\_\_\_  
Subsribers DOB: \_\_\_\_\_ Subscribers SSN: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Relationship to Subscriber: Self / Spouse / Child / Other  
Do you have SECONDARY insurance? (Circle one): Yes / No  
Insurance Company: \_\_\_\_\_ Subscribers Name: \_\_\_\_\_  
Subsribers DOB: \_\_\_\_\_ Subsribers SSN: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Relationship to Subscriber: Self / Spouse / Child / Other

**IN CASE OF EMERGENCY:**

Name of friend/relative (not living at the same address): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Best Contact No: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Dowell Dental Group. I understand that I am financially responsible for any balance incurred to my account. I authorize the Dowell Dental Group or the insurance company to release any information required to process my claims. I also authorize the Dowell Dowell Group the right to charge for cancelled appointments when I do not give notice within 2 business days.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



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**Patient PHI Authorization Form**

I, \_\_\_\_\_  
*(please print)* *(Date of Birth)*  
grant Dowell Dental Group permission to discuss my personal dental/medical  
information with the following individuals.

\_\_\_\_\_  
Name Date of Birth Relationship to Patient

\_\_\_\_\_  
Name Date of Birth Relationship to Patient

\_\_\_\_\_  
Name Date of Birth Relationship to Patient

\_\_\_\_\_  
Name Date of Birth Relationship to Patient

I understand that the information that may be discussed, includes, but is not limited to: my health history, diagnostic results, plan of care, and financial information unless otherwise restricted here:

\_\_\_\_\_  
\_\_\_\_\_

I understand that this authorization will remain in effect until terminated by myself in writing.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Signature Date



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**PATIENT DENTAL HISTORY:** Name of Previous Dentist: \_\_\_\_\_ Last Visit: \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. When was your last cleaning and exam? _____   |                          |                          |
| 2. Do your gums bleed while brushing or flossing?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to hot/cold liquids/food, sweet/sour? (circle applicable symptoms) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel any pain with your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, where do you feel the pain? _____   |                          |                          |
| 5. Do you have sores or lumps in or near your mouth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, where? _____  |                          |                          |
| 6. Have you had any head, neck, or jaw injuries within the last 10 years?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you currently experiencing the following problems in your jaw?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Clicking.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain (joint, ear, side of face).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty opening or closing.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulty chewing.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you feel that you clench or grind your teeth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If yes, more in the day or at night? (circle one)   |                          |                          |
| 10. Do you bite your cheeks/lips frequently?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had difficult extractions in the past?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had prolonged bleeding after an extraction?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had any orthodontic treatment (braces)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you wear dentures or partials? (Circle one)   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of placement _____  |                          |                          |
| 15. Have you ever received oral hygiene instructions regarding the care of your mouth?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you like your smile?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you like the color of your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any other concerns you would like to address? Please list below.               |                          |                          |

I certify that I have read and accurately answered the above questions to the best of my knowledge. I understand that providing false information can be dangerous to my health. I authorize Dowell Dental Group to release any information including diagnosis, records of any treatment, or examination rendered to me or my children during the period of such dental care to third party payors and other practitioners involved in treatment.

Signature of Patient/Guardian: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



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Current Medical Doctor: \_\_\_\_\_

Last Visit: \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| 1. Are you under medical treatment now?<br>If so, for what? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?<br>-If so, please explain on the back of this page. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medications, controlled substances, or non-prescription medications?<br>-If so, please provide a list on the back of page.              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use any tobacco products?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you wearing contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |

7. WOMEN ONLY:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| a. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you nursing?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you taking oral contraceptives?            | <input type="checkbox"/> | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| 8. Are you allergic or have had any reactions to the following? | <input type="checkbox"/> | <input type="checkbox"/> |
| -Local Anesthetics (i.e. lido/epi)                              | <input type="checkbox"/> | <input type="checkbox"/> |
| -Penicillin or other antibiotics                                | <input type="checkbox"/> | <input type="checkbox"/> |
| -Sulfa Drugs  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Barbiturates   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Sedatives  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Iodine   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Any Metals (i.e. nickel, mercury, etc...)                      | <input type="checkbox"/> | <input type="checkbox"/> |
| -Latex Rubber   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Other (please list on the back of this page)                   | <input type="checkbox"/> | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| 9. Do you have a persistent cough or throat clearing not associated with a known illness? (lasting more than 3 weeks) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever taken Fosmax, Boniva, Actonel, or any other medications containing bisphosphonates?                 | <input type="checkbox"/> | <input type="checkbox"/> |

11. Do you have or have had any of the following?

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| -High Blood Pressure                              | <input type="checkbox"/> | <input type="checkbox"/> |
| -Heart Attack                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| -Rheumatic Fever                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Swollen Ankles                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Fainting/Seizures                                | <input type="checkbox"/> | <input type="checkbox"/> |
| -Asthma   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Low Blood Pressure                               | <input type="checkbox"/> | <input type="checkbox"/> |
| -Epilepsy/Convulsions                             | <input type="checkbox"/> | <input type="checkbox"/> |
| -Leukemia   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Diabetes<br>-If yes, do you take medicine? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| -Kidney Diseases                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| -AIDS or HIV Infection                            | <input type="checkbox"/> | <input type="checkbox"/> |
| -Any Bodily Implant                               | <input type="checkbox"/> | <input type="checkbox"/> |
| -Hepatitis/Jaundice                               | <input type="checkbox"/> | <input type="checkbox"/> |
| -History of Sexually Transmitted Disease          | <input type="checkbox"/> | <input type="checkbox"/> |
| -Stomach Troubles/Ulcers                          | <input type="checkbox"/> | <input type="checkbox"/> |
| -Chest Pain                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| -Easily Winded                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| -Thyroid Problem                                  | <input type="checkbox"/> | <input type="checkbox"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| -Glaucoma  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Heart Disease                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| -Pacemaker   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Heart Murmur  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Recent Weight Loss                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Liver Disease                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| -Stroke  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Hay Fever/Allergies                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| -Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Radiation/Chemo Therapy                             | <input type="checkbox"/> | <input type="checkbox"/> |
| -Respiratory (breathing) issues                      | <input type="checkbox"/> | <input type="checkbox"/> |
| -Mitral Valve Prolapse                               | <input type="checkbox"/> | <input type="checkbox"/> |
| -Angina  | <input type="checkbox"/> | <input type="checkbox"/> |
| -Anemia any type                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| -Emphysema   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Cancer<br>-If yes, what type? _____<br>-When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| -Arthritis   | <input type="checkbox"/> | <input type="checkbox"/> |
| -Any Prosthetic Joint Replacement                    | <input type="checkbox"/> | <input type="checkbox"/> |

**\*If you have a list of medications/vitamins that you take, please attach it to this page or write it on the back.\***

I certify that I have read and accurately answered the above questions to the best of my knowledge. I understand that providing false information can be dangerous to my health. I authorize Dowell Dental Group to release any information including diagnosis, records of any treatment, or examination rendered to me or my child during the period of such dental care to third party payors and other practitioners.

Print Name: \_\_\_\_\_ Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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## FINANCIAL GUIDELINES

**WELCOME** and **THANK YOU** for choosing Dowell Dental Group as your dental health provider. Our financial goal is to offer state of the art treatment at an affordable investment leading to improved oral health. Our recommendations are based on the needs of our patients rather than the limitations of insurance companies. Our practice submits your dental insurance claim as a courtesy to you. **All fees incurred during treatment are your responsibility regardless of your insurance coverage.**

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Please indicate your preferred method of payment:

\_\_\_\_\_ Cash

\_\_\_\_\_ Check

\_\_\_\_\_ Credit Card (MC, Visa, Discover)

\_\_\_\_\_ CareCredit upon approval @ carecredit.com (We are happy to assist you if needed)

NOTE: Return checks will be subject to an additional fee of \$35 per returned check. If it becomes necessary to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal fees incurred.

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Dowell Dental Group. I understand that the responsibility for payment for all dental treatment provided in this office, for myself and/or my dependents, is mine. I agree that finances are due and payable at the time services are rendered, unless other written and signed financial arrangements have been made.

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Patient Signature/Parent of Dependent Child

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Date



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I have received a copy of Dowell Dental Group's Notice of Privacy Practices

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\*You may refuse to sign this acknowledgement\***