DOWELL DENTAL GROUP
General - Restorative - Cosmetic

www.dowelldental.com

PERSONAL/DEMOGRAPHIC 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?_____

INSURANCE INFORMATION:

Responsible 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:_____
Subscribers 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:_____
Subscribers 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?	☐	☐
3. Are your teeth sensitive to hot/cold liquids/food, sweet/sour? (circle applicable symptoms)	☐	☐
4. Do you feel any pain with your teeth?	☐	☐
a. If yes, where do you feel the pain?_____		
5. Do you have sores or lumps in or near your mouth?	☐	☐
a. If yes, where?_____		
6. Have you had any head, neck, or jaw injuries within the last 10 years?	☐	☐
7. Are you currently experiencing the following problems in your jaw?	☐	☐
a. Clicking	☐	☐
b. Pain (joint, ear, side of face)	☐	☐
c. Difficulty opening or closing	☐	☐
d. Difficulty chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you feel that you clench or grind your teeth?	☐	☐
a. If yes, more in the day or at night? (circle one)		
10. Do you bite your cheeks/lips frequently?	☐	☐
11. Have you had difficult extractions in the past?	☐	☐
12. Have you had prolonged bleeding after an extraction?	☐	☐
13. Have you had any orthodontic treatment (braces)?	☐	☐
14. Do you wear dentures or partials? (Circle one)	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygeine instructions regarding the care of your mouth?	☐	☐
16. Do you like your smile?	☐	☐
17. Do you like the color of your teeth?	☐	☐
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 practicioners 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? If so, for what? _____	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? -If so, please explain on the back of this page.	☐	☐
3. Are you taking any medications, controlled substances, or non-prescription medications? -If so, please provide a list on the back of page.	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use any tobacco products?	☐	☐
6. Are you wearing contact lenses?	☐	☐

	Yes	No
7. WOMEN ONLY:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

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

	Yes	No
9. Do you have a persistent cough or throat clearing not associated with a known illness? (lasting more than 3 weeks)	☐	☐
10. Have you ever taken Fosmax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐	☐

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

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

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

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 practicioners.

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 recomendations 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.**

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.

_____ _____

Patient Signature/Parent of Dependent Child 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