Dr. David R. Bowser III & Dr. Nicholas T. Hyde
Cosmetic & Family Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to complete this form. If you have questions, we will be glad to assist you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name: _____ Today's Date: _____
First MI Last

Home Address: _____ Date of Birth: _____

_____ Home Phone: _____

Sex: (Circle One) ☐ Male ☐ Female

SS#: _____ Email: _____ Cell Phone: _____

(If a minor) Name of responsible party: _____

Relationship to patient: _____ Home Phone: _____

Address: _____

Patient Medical History

Please check if you have ever had any of the following:

___ Heart Disease	___ Anemia	___ Thyroid Disease
___ Heart Murmur	___ Liver Disease	___ High Blood Pressure
___ Heart Attack	___ Hepatitis	___ Low Blood Pressure
___ Chest Pain (Angina)	___ Bleed Easily	___ Stroke
___ Congenital Heart Defect	___ Jaundice	___ Stomach Ulcer/Problems
___ Rheumatic Fever	___ HIV/AIDS	___ Radiation Therapy
___ Mitral Valve Prolapse	___ Glaucoma	___ Cancer
___ Shortness of Breath	___ Kidney Disease	___ Recent Weight Loss
___ Sexually Transmitted Disease	___ Sinusitis	___ Swelling of Hands & Feet
___ Psychiatric Treatment	___ Diabetes	___ Respiratory Problems
___ Fainting Spells/ Dizziness	___ Convulsions	___ Tuberculosis
___ Asthma	___ Epilepsy	___ Bad reaction to anesthetic
___ Joint Replacement or Implant	___ Other _____	___ Allergies? To what? _____
___ Medications for osteoporosis	___ Currently Pregnant	

- Are you under the care of a physician at the present time for a medical condition?
  (Circle One) ☐ Yes ☐ No If yes, please explain _____
- Have you ever had any serious illness or operations within the last 5 years?
  (Circle One) ☐ Yes ☐ No If yes, please explain _____

_____

_____

Current Medications – If none, check here: ____
(Prescription and Over-the-Counter)

Medication	Reason	Medical History Update: (Office Staff Only)	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Authorization

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____ _____

Patient/representative signature Date

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my protective health information to the following individuals: (this information could include name, diagnosis, test results, images and account information.)

Name and relationship to patient: _____

I understand the above information and agree with its contents, and this will serve as my signature for the HIPPA disclosure form.

_____ _____

Patient/representative signature Date