Bowling & Dunn Family Dentistry

1412 Blizzard Drive • Parkersburg, WV 26101
304.424.6100

1 ABOUT YOU

Today's Date:_____

NAME:_____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate:_____/_____/_____ SS#:_____

Home Address:_____
APT./CONDO

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Child

Home#:_____ Cell#:_____

Work#:_____ Ext:_____

Email Address:_____

Employer:_____

Employer's Address:_____

How Long There:_____ Occupation:_____

Where & When are the best times to reach you?_____

Other family members seen by us:_____

Previous / Present Dentist:_____

Last Visit Date:_____

What are your hobbies and interests?_____

_____

_____

How did you hear about us?_____

2 SPOUSE / PARENT / GUARDIAN

His/Her Name:_____

Employer:_____

Wk#:_____ Ext:_____ DL#_____

Birthdate:_____/_____/_____ SS#:_____

Person responsible for account:_____

Wk#:_____ Ext:_____ Hm#_____

Billing Address:_____

Relation:_____ SS#:_____

Employer:_____ DL#:_____

OFFICE USE ONLY

MEDICAL ALERTS

Major Medical Alert ❑ Yes ❑ No

Pre-Medication ❑ Yes ❑ No

Bisphosphonate ❑ Yes ❑ No

Blood Thinner ❑ Yes ❑ No

Allergy_____

_____

3 DENTAL INSURANCE

We are happy to submit claims to your insurance company on your behalf as a courtesy to our patients. Our office will make every effort to advocate for our patients with their insurance company. However, our office is not a party to your insurance contract. If your insurance company fails to pay all or part of the services provided by our office you are responsible for payment of those fees.

PRIMARY DENTAL INSURANCE

Insurance Co. Name:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:____/____/____ Insured's SS#:_____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:____/____/____ Insured's SS#:_____

Insured's Employer:_____

4 DENTAL HISTORY

Why have you come to the dentist today?_____

_____

_____

Do you need pre-medicated with antibiotics? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Have you ever had Orthodontic treatment? ❑ Yes ❑ No

Your current dental health is: ❑ Poor ❑ Fair ❑ Good

Do you like your smile?_____

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss?_____

How many times a day do you brush?_____

Types of bristles? ❑ Hard ❑ Medium ❑ Soft ❑ Power brush

How fearful are you of visiting the dentist?

Very_____ Average_____ Not Very_____

Are you interested in long-term dental care?_____

Do you use tobacco? ❑ Yes ❑ No

How many years_____ What type_____ How frequent_____

Are you interested in quitting? ❑ Yes ❑ No

5 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone #: (_____)_____ Date of last visit:_____

Your current physical health is: ❑ Poor ❑ Fair ❑ Good

Are you taking any prescription or

over-the-counter drugs? ❑ Yes ❑ No

Please list each one:_____

_____

_____

_____

Preferred Pharmacy?_____

Have you ever taken a Bisphosphonate? ❑ Yes ❑ No

Which one?_____ When?_____

Do you take a blood thinner? ❑ Yes ❑ No

Which One?_____

For Women: Are you taking birth control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:_____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves

When?_____

Explain?_____

_____

_____

Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy

When?_____

What part of the body?_____

_____

_____

Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes ❑ Type I ❑ Type II
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma

Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery

When?_____

Y N Hemophilia
Y N Hepatitis Type?_____
Y N Herpes
Y N High Blood Pressure
Y N HIV +/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Organ Transplant

_____

_____

Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers

Please list any other medical condition(s) that you have ever had:

_____

_____

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Jewelry/Metals
Y N Sulpha
Y N Dye_____
Y N Cinnamon
Y N Other

Please list any drugs that you are allergic to:

_____

_____

_____

_____

6

In the event of an emergency, we need the name of someone who does not live in your home that we can contact.

His/Her Name:_____ Relation:_____

Wk #: (_____)_____Hm #: (_____)_____

7

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I accept full responsibility for charges incurred as a result of dental treatment and agree to pay any legal fees or court costs associated with collecting any balance due.

_____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

8

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

1. Date:_____ Initial:_____

2. Date:_____ Initial:_____

3. Date:_____ Initial:_____

4. Date:_____ Initial:_____

5. Date:_____ Initial:_____

6. Date:_____ Initial:_____