# 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:_____

# Dental Insurance Information Form

This form is for dental coverage only. The information you provided will be used to verify your benefits so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without the information we are unable to file your claim.

**Patient** name: _____ **Patient** DOB: _____

**Primary** Insurance: _____ Ins. Co. Phone # _____

Insurance address: _____

**Subscriber's** full name: _____Relationship to patient: _____

**Subscriber's** DOB: _____ Subscriber ID: _____

Group # _____ Employer: _____

Is the patient covered by a secondary dental insurance plan? If yes, complete the following:

**Secondary** Insurance: _____ Ins. Co. Phone # _____

Insurance address: _____

**Subscriber's** full name: _____ Relationship to patient: _____

**Subscriber's** DOB: _____ Subscriber ID: _____

Group # _____ Employer: _____

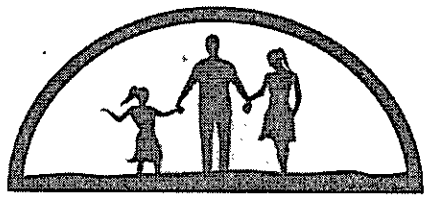
I agree to be responsible for all charges for dental services not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan to write off a portion of the charges. I authorize the disclosure of my protected health information for treatment, payment and healthcare operations and the electronic, paper, fax or verbal transmission of protected health information to a clearinghouse as well as to and from my insurance company (ies), it's employees and authorized representatives. I authorize the disclosure of my protected health information to my employer and my employer's personnel office for the purpose of processing my insurance claims or verification of coverage relating to my dental treatment and collecting unpaid balances for services rendered.

Signature: _____ Date: _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dentist named herein.

Signature: _____ Date: _____

**Bowling & Dunn Family Dentistry**
**1412 Blizzard Drive * Parkersburg, WV 26101**
**304.424.6100 – 304.424.5353 (fax)**
**Tax ID# 31-1018574**



BOWLING & DUNN
**FAMILY DENTISTRY**

1412 Blizzard Drive Parkersburg, WV 26101
304-424-6100 / Fax 302-424-5333

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

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For office Use Only

We attempted to obtain acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us obtaining acknowledgment
- Other (please specify):

Bowling & Dunn Family Dentistry
1412 Blizzard Drive
Parkersburg, WV 26101
(304) 424-6100 (phone)
(304) 424-5333 (fax)

Thank you for choosing Bowling & Dunn Family Dentistry for your dental care needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several different payment options.

1. Cash, checks or money orders
2. Credit cards
3. Care Credit (no interest payment plans available)

Please note: Payment is required upon completion of your treatment.
For patients with insurance, we are happy to work with your carrier to maximize your benefits and direct bill them as a courtesy to you. Estimated co-payments and deductibles are required at the time of service. Any balance not paid within 90 days from the date of service may be subject to a collection process.

We charge $30 for returned checks and an additional $6 if the bank reprocesses the check.

We kindly ask for a 24-hour notice to cancel or reschedule. We understand unexpected events arise and we try to work with families the best we can. A $50 fee is charged for patients who miss two appointments in a 12-month period. We reserve the right to dismiss a patient if there is not a two-hour notice given. If there are three or more missed appointments in a year, the patient and family may be dismissed from the practice. If a patient is dismissed, we will provide emergency dental care for the next 30 days. After that time, no services will be provided. You may contact us to have your records transferred to your new dentist.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient name (print) _____ Date _____

Patient, parent or guardian signature _____

BOWLING & DUNN
FAMILY DENTISTRY

## Release of Protected Health Information

I, _____ authorize the disclosure of my protected health information (treatment records, appointments, and billing information) to the following individual/s.

_____ Relationship to patient:_____

_____ Relationship to patient:_____

_____ Relationship to patient:_____

I give authorization to disclose all information beginning:

Starting Date: _____/_____/_____

End Date: _____/_____/_____

I understand that I may withdraw or revoke my permission at any time. If I wish to withdraw my permission, my information may no longer be used or released. I may revoke this authorization by notifying, in writing, Bowling and Dunn Family Dentistry.

Printed Patient Name _____

Date of Birth _____/_____/_____

Patient Signature _____

Date _____/_____/_____

1412 Blizzard Drive, Parkersburg, WV 26101 ---- P: (304)424-6100 ---- F: (304)424-5333 ---- E: info@bowlingdunnfamilydentistry