Bowie Family Dental
REGISTRATION FORM
(Please Print)

Today's date:	Primary Care Physician Name/Phone#:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Preferred Name:

Home # Work #	Cellular # Email	Preferred method of contact	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	P.O. Box	City/State/ZIP:

Occupation:	Employer:	Social Security #	Drivers License #

Chose office because/Referred to office by (please check one box):	❑ Website	❑ I was a previous patient	❑ Newspaper

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Whom may we thank for your referral?

RESPONSIBLE PARTY

Responsible Party	Birth date: / /	Address (if different):	Home # Cellular #

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer # ( )

Patient's relationship to responsible party	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship to patient:	Home # Cellular#	Work #

DENTAL HISTORY

Reason for today's visit	Previous Dentist	Date of last visit	Date of last x-rays

Have you ever had any complications with previous dental treatment? If yes, please describe

Have you ever had any unpleasant experiences with dental treatment? If yes, what can we do to make you more comfortable?

Please check if you have had trouble with any of the following:

❑ Bad breath	❑ Food collecting between teeth	❑ Dry mouth	❑ Sensitivity to biting
❑ Bleeding gums	❑ Grinding teeth	❑ Sensitivity to cold	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Loose teeth or broken fillings	❑ Sensitivity to hot	❑ Sores or growths in your mouth

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): Relationship to patient: Home # Cellular# Work #

The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

BOWIE
EST. 2016
FAMILY DENTAL

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____ Date Created _____

Are you under a physician's care now? ◯ Yes ◯ No If yes: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you...

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Welcome to our practice!

1. **Appointment Guidelines**

As a courtesy of our office, we will be contacting you before your appointment as a reminder. If for any reason you are unable to keep your appointment, we do request a two day notice of change as your appointment time has been specifically reserved for you. We will do everything we can to respect your time and ask that you do the same.

2. **Financial Guidelines**

If you wish to make use of insurance benefits as a financial assistance, we ask that you provide adequate benefit information so that we can maximize benefits and provide the most accurate estimation of coverage as possible. Any portion not covered with the estimated benefits will be due at the time of the service. Likewise, we ask that you keep in mind that insurance coverage for services provided at this office is only an estimation. Any leftover balance is the responsibility of the responsible party to make payment to in a timely manner. By signing below, you are authorizing this office to affix your name to any and all claims or documents as related to any of your dental benefits due to you and your dependents through your insurance. You are also authorizing payment of dental benefits directly to Bowie Family Dental. This "signature on file" will be valid from this date and continue to be valid until canceled through written notice to this office.

Any balance that is not paid within 25 days of the billing date will incur a service charge of at least $5 and at most $25 for each monthly billing period. If you default, you promise to pay any and all collection costs incurred to affect the collection of your account. Payment can be made in the form of cash, check, debit, credit card, Care Credit, or American Healthcare Finance.

To the best of my knowledge, I have answered the registration and medical questions accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. I understand that I am financially responsible for all services and remaining balances not paid for in entirety with my insurance benefits or without insurance benefits.

_____ _____

Patient or Responsible Party Signature Date

Acknowledgment of Receipt of Privacy Practices

You may refuse to sign this acknowledgment

I, _____, have read and understand this office's Notice of Privacy Practices.

Printed Name_____

Signature _____

Date _____

Office Use Only

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

_____Individual refused to sign

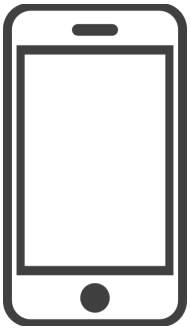
_____Communications barriers prohibited obtaining the acknowledgment

_____Other (Please specify)_____

TEXTING POLICIES

Texting is a great way for us to communicate with you if you have a cell phone contact number. If you would like to be contacted via text for certain circumstances, please fill out your information below. If not, please write your name below and mark "I decline texting services."

I grant Bowie Family Dental permission to contact me under these conditions:



- Confirming appointments
- Schedule changes
- Account activity (ex: outstanding balances)
- Other alerts (ex: service ratings)

Cell Number: _____

Name: _____ Date: _____

Signature: _____

☐ I decline texting services

Please keep in mind that we strive to make connections with our patients. We will do our best to respect your preferences, but under some circumstances we may use a different method. That being said, please select the method of contact that you would prefer.

☐ If possible, I prefer text

☐ If possible, I prefer a call

☐ I would enjoy call or text