BARRY L. BOWDEN D.D.S., M.A.G.D.
Restorative, Reconstructive and Esthetic Dentistry
Master in Academy of General Dentistry
7200 Highway 71 West
Austin, Texas 7873
(512) 288-2823

DATE: _____

PERSONAL INFORMATION

Name_____

Date of Birth_____/_____/_____Social Security#_____-_____-_____

Marital Status (Circle one) Married Divorced Single Widowed

Home Address_____City_____Zip_____

Home Phone_____Cell Phone_____

Email_____

Employer_____ Work Phone_____

Occupation_____

SPOUSE INFORMATION

Name _____Date of Birth_____/_____/_____

Spouse Employer _____Work Phone_____

Occupation_____

Whom may we thank for referring you to our office?

_____

If you are covered by Dental Insurance, please complete the following:

Insurance Company Name_____

Policy Holder Name_____

Policy Holder Employer_____Work #_____

Date of Birth_____/_____/_____SS#_____-_____-_____Subscriber ID#_____

Ins. Comp. Address_____City_____Zip_____

Ins. Comp. Phone#_____Group#_____

MEDICAL INFORMATION **Circle YES or NO**

Are you now or have you been under a physician's care within the past 2 years? Yes No

Physician's name_____Phone_____

Do you take any medications, such as aspirin, decongestants, tranquilizers, etc? Yes No

If so, what? _____

Do you have any allergies such as food, pollen? Yes No

Are you sensitive to any drugs such as penicillin, Novocain, aspirin or codeine? Yes No

If so, what? _____

Do you bleed excessively after getting a cut, wound or surgery? Yes No

Have you ever had any breathing difficulty such as asthma, emphysema, chronic Yes No

Cough, pneumonia, tuberculosis or other lung disorders? Yes No

If yes, Explain_____

Are you pregnant Yes_____No ____ If Yes, Expected delivery date_____?

Do you have a current medical problem? ---------- Yes No

Have you ever had heart problems? ---------- Yes No

Have you ever had rheumatic fever? ---------- Yes No

Have you ever had hepatitis or liver disease? ---------- Yes No

Have you ever had kidney disease? ---------- Yes No

Have you ever had high or low blood pressure? ---------- Yes No

Do you have diabetes? ---------- Yes No

Have you ever had anemia? ---------- Yes No

Have you ever had a stroke? ---------- Yes No

Have you ever had cancer or a tumor? ---------- Yes No

Have you ever had radiation treatment? ---------- Yes No

Have you ever had chemotherapy? ---------- Yes No

Have you ever had joint replacement surgery? ---------- Yes No

If so, what type and when? _____ Yes No

Do you have any condition that affects your immune system? ---------- Yes No

Do you have frequent headaches? ---------- Yes No

Have you ever had arthritis? ---------- Yes No

Have you ever had stomach trouble? ---------- Yes No

Do you have hay fever? ---------- Yes No

Have you ever had tuberculosis? ---------- Yes No

Do you routinely eat breakfast? If so, what? ---------- Yes No

Do you use tobacco? Frequently? ---------- Yes No

Is your diet medically supervised? ---------- Yes No

DENTAL INFORMATION

What is your immediate dental concern? _____

Are you presently in dental pain? _____

Have you had orthodontic treatment (braces)? ---------- Yes No

Have you had periodontal treatment for gum disease? ---------- Yes No

How do you feel about your past dental experiences? _____

Do you have any growth or swellings in my mouth or neck? ---------- Yes No

Do you have any difficulty swallowing? ---------- Yes No

Do your gums bleed when brushing? ---------- Yes No

Have you ever been told you had gum disease? ---------- Yes No

If so when? _____

Do you have an unpleasant odor in your mouth? ---------- Yes No

Is any place in your mouth sensitive to pressure? ---------- Yes No

Is any place in your mouth sensitive to heat? ---------- Yes No

If so, where? _____

Is any place in your mouth sensitive to cold? ---------- Yes No

Do you ever have a burning tongue? ---------- Yes No

Have you ever had a reaction to dental anesthetic? ---------- Yes No

Does food catch between you teeth? ---------- Yes No

Do you use dental floss? ---------- Yes No

Are you aware of stiff neck muscles? ---------- Yes No

Are you aware of clenching your teeth at night? ---------- Yes No

Have you ever been told you grind your teeth at night? ---------- Yes No

Do you have clicking or popping in your jaw joints? ---------- Yes No

Do you have difficulty in opening your mouth widely? ---------- Yes No

Do you have any discomfort when chewing? ---------- Yes No

Do you have tension headaches? ---------- Yes No

Do you have sinus problems? ---------- Yes No

Do you have difficulty sleeping? ---------- Yes No

Is there anything about the appearance of your teeth that you would like to change? Yes No

What? _____

Do you feel you will eventually wear artificial dentures? ---------- Yes No

Do you think you have active dental disease? ---------- Yes No

Do you want to retain your teeth for life? ---------- Yes No

Do you have removable bridge work? ---------- Yes No

Do you have fixed bridge work? ---------- Yes No

How long has it been since your last dental cleaning? _____

How long has it been since you had dental x-rays made? _____

I, the undersigned, authorize dental treatment to be rendered by the dentist and his staff, and I assume financial responsibility for the treatment.

Patient Signature_____

<u>Patients with Dental Insurance</u>:

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Barry Bowden. I understand I am responsible for fees not paid by my dental insurance, on the day of my treatment.

Patient Signature_____

PATIENTS WITH INSURANCE BENEFITS

As a service to our patients we will complete and send your insurance claim to your insurance company. However, our professional treatment is rendered to YOU, not the insurance company; therefore YOU are responsible for all treatment and payments. *On the day of your treatment you will be responsible for your yearly deductible plus any itemized co-payment, depending on your yearly maximum availability.*

Your dental insurance is based on a contract between your employer and the insurance company. We will attempt to estimate your dental benefits to the best of our ability, *this is an estimate ONLY, and should not be depended on as the final decision.* If there is an additional balance due after the insurance has paid, you will be responsible for that balance. Should questions arise, it is best to contact your insurance company directly.

This office will provide at your request all pertinent information to your insurance company, and we will do our best to help you maximize your available benefits.

Dental Insurance is an aid to obtaining dental care and rarely covers services more than 1/3 or ½ of the total cost. Most policies state that they cover a percentage of the "usual and customary fee." However, they are the ones who set these fees, and they are not always the same as the fees that we charge in our office. All these factors combine to reduce the benefits within the structure of your particular dental plan.

We accept Checks, Cash, MasterCard, Visa, Discover & CareCredit

I have read, understand and agree to the above.

X_____

PATIENTS WITHOUT INSURANCE BENEFITS

WE RESPECTFULLY REQUEST THAT ALL FEES BE PAID AT THE TIME SERVICES ARE RENDERED, unless prior arrangements were made.

Please ask the Office Manager for our payment plans that we have available for you, so that you can get the optimum dental care you need.

If you have any further questions, please don't hesitate to ask our Office Manager.

We accept Checks, Cash, MasterCard, Visa, Discover & CareCredit

I have read, understand and agree to the above.

X_____

Barry L. Bowden, D.D.S., M.A.G.D

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be us4ed to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information's used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extend that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Barry L. Bowden, D.D.S., M.A.G.D
7200 Highway 71 West
Austin, Texas 78735
(512)288-2823