**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 78735**
**(512) 288-2823**

**PERSONAL INFORMATION**

Name_____

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

Marital Status (Circle one) Married Single Widowed

Home Address_____City_____Zip_____

Home Phone_____Cell Phone_____

Email_____

Employer - Self _____ Work Phone_____

Occupation_____

**SPOUSE INFORMATION**

Name _____Date of Birth_____/_____/_____

Spouse Employer _____Work Phone_____

**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#_____-_____-_____

Ins. Comp. Address_____City_____Zip_____

Ins. Comp. Phone#_____Group#_____

**Yes No**

[ ] [ ] 1. Are you now or have you been under a physician's care within the past 2 years?

Physicians name_____Phone_____

[ ] [ ] 2. Do you take any medications, such as aspirin, decongestants, tranquilizers, etc?

If so, what? _____

[ ] [ ] 3. Do you have any allergies such as food, pollen? Yes_____ No_____

[ ] [ ] 4. Are you sensitive to any drugs such as penicillin, Novocain, aspirin or codeine?

If so, what? _____

[ ] [ ] 5. Do you bleed excessively after getting a cut, wound or surgery? Yes____ No____

[ ] [ ] 6. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy?

_____

[ ] [ ] 7. Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis or other lung disorders? Yes _____No_____

If yes, Explain_____

[ ] [ ] 8. Are you pregnant Yes_____No ____

**Have you ever had any of the following?**

Yes No

[ ] [ ] Heart Problems?
[ ] [ ] Hepatitis or liver disease?
[ ] [ ] High or low blood pressure
[ ] [ ] Anemia?
[ ] [ ] Chemoptherapy?
[ ] [ ] Sinus problems?
[ ] [ ] Rheumatic fever?
[ ] [ ] Kidney disease?
[ ] [ ] Diabetes?
[ ] [ ] Radiation treatment?
[ ] [ ] Headaches?
[ ] [ ] Arthritis?
[ ] [ ] Stomach trouble?

**Dental History**

1. What is your main dental concern?_____
2. How do you feel about the appearance of your teeth?_____
3. Please comment about your previous dental experience_____

   _____
4. Do you have any discomfort when chewing?_____
5. Last dental cleaning (approx. date) _____Date of last x-rays_____

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

Patient Signature_____Date_____

## 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_____

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## 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: _____

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