WELCOME

Michael D. Bowen D.D.S., P.C.
Christina M. Behring, D.D.S.

To help us meet all your health care needs, please fill this form out completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

First Name _____ M.I. _____Last Name _____Birth date_____
Home Phone _____ Work Phone _____Soc. Sec #_____
Circle Appropriate Status: Minor Single Married Divorced Widowed Sex: Male Female
Home Address_____ City _____ State ____ ZIP_____E-Mail _____
Cell Phone _____Emergency Contact _____Phone _____

Responsible Party

Name of Person Responsible for this Account _____Relationship to Patient_____
Address _____City, State & Zip _____
Home Phone _____ Soc. Sec. # _____ Birthday _____
Employer _____ Work Phone _____Cell Phone _____
Dental Insurance Company _____ Group # _____
Payment is due in full at the time of service. We accept cash, personal checks, Visa, Discover, MasterCard, American Express, and most debit cards.

Medical History

Name of physician_____Phone _____

Do you smoke? Y N How much? _____
Do you have a frequent cough? Y N
Do you have difficulty breathing through your nose? Y N
Have you ever had hives, weakness or
Difficulty after an injection? Y N
Do you bruise easily? Y N
Are there any unlisted health conditions your doctor should
Know about? Y N (if yes please explain) _____
_____
_____
_____

Are your teeth sensitive to hot or cold liquids/food? Y N
Do you have any sores or lumps in your mouth? Y N
Do you clench or grind your teeth? Y N
Have you had orthodontic treatment? Y N
Do you wear dentures or partials? Y N
Do you like your smile? Y N
Current dental concerns? _____
_____
_____
_____
_____

Have you been told that you need to take an antibiotic before dental treatment? Y N
Are you currently under the care of a physician for a continual medical condition? Y N
When was your last dental visit? _____

Please list any medications you are taking and what for

List any hospitalizations with in the last five years

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Are you allergic to:

Antibiotics	Y N
Aspirin	Y N
Barbiturates	Y N
Codeine	Y N
Latex	Y N
Local anesthetic	Y N
Penicillin	Y N
Sedatives	Y N
Sulfa drugs	Y N
Any Metals (e.g. nickel, mercury)	Y N

Other_____

For Women Only

Are you Pregnant now? Y N

if yes week #_____

Are you breastfeeding? Y N

Are you taking birth control pills? Y N

Please answer **all** questions by circling Yes (Y) or No (N) to any conditions that you have or have had

Y N Heart Murmur	Y N Blood Disorder	Y N Hypoglycemia	Y N Arthritis
Y N Heart Attack	Y N Hemophilia	Y N Tumors or Growths	Y N Physical Disability
Y N Stents	Y N Anemia	Y N Malignancies/ Cancers	Y N ADD
Y N Pacemaker/defibrillator	Y N Blood Transfusions	Y N Radiation Treatments	Y N Autism
Y N Artificial Heart Valve	Y N HIV Positive	Y N Chemotherapy	Y N Sinus Condition
Y N Artificial Joints	Y N Hepatitis-type _____	Y N Liver Disorders	Y N Fainting
Y N Bone Replacement	Y N High Blood Pressure	Y N Glaucoma	Y N Eating Disorder
Y N Heart Surgery	Y N Low Blood Pressure	Y N Nervous Problems	Y N Hearing Problem
Y N Mitral Valve Prolapsed	Y N Diabetes	Y N Asthma	Y N Speech Problem
Y N Stroke	Y N Epilepsy/Seizures	Y N Emphysema	Y N Acid Reflux
Y N Organ Transplant	Y N Circulatory Problems	Y N Tuberculosis	Y N Psychiatric Care
Y N Any Heart Disease	Y N Thyroid Disorders	Y N Ulcer	Y N Frequent Headaches
Y N Rheumatic Fever	Y N Kidney Disorders	Y N Frequent Dry Mouth	Y N Swollen Ankles
Y N Fever Blisters	Y N Drug Dependency	Y N Alcohol Dependency	Y N Chest Pain

To the best of my knowledge, the foregoing questions have been accurately answered. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I grant the right to the dentist to the release health information obtained from me, and information about my dental treatment to third party payers, and /or other health practitioners. I understand that the practice routinely confirms appointments and reminders about premedication and may leave messages on an answering machine, voice mail, e-mail, postcards, or with another family member. The signature on file is my authorization for the release of information necessary to process my claim and received the Notice of Privacy Practices from this practice.

_____ _____

Signature of patient, parent or guardian Date Signature of Witness Date

Names of Minor Children:

_____ _____

_____ _____

_____ _____