PERIODONTICS

ASA:_____ Chart #:_____

PATIENT INFORMATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY

Patient's Name _____
First Middle Initial Last

Date of Birth _____ Today's Date _____

Sex _____ Weight _____ Height _____ Social Security # _____

Circle One: Married Single Child Other_____

Spouse/Guardian Name _____

Residential Address: _____
Street

_____
City State Zip

Phone: _____ Cell: _____

I allow Scott Dowell DDS to contact me through text messages: Yes / No

Email: _____ Preferred Pharmacy: _____

Employed by _____

Name of Referring Dentist _____

How long have you been under his/her care? _____

Name of Physician _____ Phone: _____

Why were you referred to a periodontist? _____

Are you covered by Dental Insurance? _____

Dental Insurance Policy Holders Name _____

Date of Birth _____ Social Security # _____

Employed by _____

Patient's Relationship to Insured _____

Name and Address of Carrier _____

_____

Group Number _____ ID Number _____

Person to Notify in Case of Emergency _____

Relation: _____ Phone: _____

Turn Over →

GENERAL HEALTH

Circle One: What is your estimation of your general health? GOOD – FAIR – POOR

Circle One:

Yes No Are you now under the regular care of a physician?

If so, for what? _____

When was your last physical examination? _____

Yes No Have you had any major operations, hospitalization or illnesses?

If so, for what? _____

Yes No Are you taking any pills, medication, or drugs? Please list or attach a list.

_____

_____

Yes No Are you taking any medication for osteoporosis? _____

Yes No Have you had any unusual reaction or allergies to any medications or foods?

If so, please list. _____

Have you ever had a reaction to any of the following: (PLEASE CHECK)

____ Penicillin
____ Sulfa drugs
____ Codeine
____ Aspirin
____ Bisphosphonates
____ Latex
____ Tetracycline
____ Dental anesthetic (Novocain)
____ Nitrous oxide (laughing gas)
____ Other _____

Yes No Do you smoke? If so, how many a day? _____

Yes No Do you drink alcohol?

Yes No Are you on a diet of any kind?

Yes No Has any member of your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? _____

Do you have or have you ever had: (PLEASE CHECK)

____ Allergies
____ Anemia
____ Anxiety
____ Arthritis
____ Artificial Joints – _____
____ Asthma
____ Blood Disease
____ Cancer - _____
____ Diabetes
____ Dizziness
____ Epilepsy
____ Excessive Bleeding
____ Glaucoma
____ Head Injuries
____ Heart Disease
____ Heart Murmur
____ Hepatitis
____ High Blood Pressure
____ HIV
____ Jaundice
____ Kidney Disease
____ Liver Disease
____ Pacemaker
____ Radiation Treatment
____ Rheumatic Fever
____ Sinus Problems
____ Stomach Problems
____ Stroke
____ Tuberculosis
____ Tumors
____ Ulcers
____ Venereal Disease
____ Other
_____
_____
_____

Yes No Are you excessively nervous or depressed?
Yes No Have you ever been treated for nervous or mental disorders?
Yes No Do you find it necessary to sleep using two pillows?
Yes No Have you recently gained or lost excessive amounts of weight?
Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

WOMEN ONLY:

Yes No Are you pregnant? Due date:
Yes No Are you taking birth control pills?
Yes No Have you reached menopause?

DENTAL HEALTH

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing ability?

Have you ever had:
____ Orthodontic treatment (braces)
____ Oral surgery (extraction, etc.)
____ Periodontal treatment
____ Your teeth ground or bite adjusted
____ A bite plate or other appliance

Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to become caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum disease ( ) Other ( )
Yes No Have missing teeth been replaced?
Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

Do you:
____ Clench or grind your teeth while awake or asleep?
____ Bite your lips or cheeks regularly?
____ Hold foreign objects with your teeth?
____ Breathe primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____

How long before that? _____

How often do you see your dentist? _____

How often and when do you brush your teeth? _____
Do you use: Hand toothbrush ( ) Electric toothbrush ( )
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
What else do you use to clean your teeth? (floss, toothpick, Waterpik, etc.) _____

How often? _____

Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Does the fear of pain make you postpone your dental treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minutes a day in order to keep your natural teeth?

Turn Over →

Consent for Services

In consideration of both this office and other patients this office services, patients missing multiple appointments without 24 hours' notice are subject to dismissal at the discretion of this office.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment by the patient for their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for the prescribed dental care can only be extended for a period of six months from the date of the patient examination, at which time charges for care will be adjusted to the amount that is current for the procedures listed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X

Name of Patient or Legal Guardian

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

Please Print Name

X

Signature

Date

If you are not available at the time when we call and would like to have a representative to speak on your behalf, please print the name and relationship to you/patient of each designee below:

Designee Name: X	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

Payment Policy

Thank you for choosing us to serve your periodontal needs. We are committed to providing you with quality and affordable dental care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We are not in network with any insurance company, but will file your insurance claim, as a courtesy to you. We will file a predetermination to obtain estimated coverage for your procedures, but if this is not returned by your insurance company at the time of your procedure, payment in full is expected and insurance will reimburse you. Due to the vast number of insurance plans, knowing your specific insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.

3. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

6. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice.

7. Missed appointments. Our policy is to charge $50 per scheduled hour for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

X

_____ _____

Signature of patient or responsible party **Date**

Turn Over →

Scott M Dowell, DDS MS PA
4601 Buffalo Gap Rd, Ste A3
Abilene, Texas 79606
325-437-3456
dowelldds@gmail.com

Patient Photo Release Form

I _____, hereby authorize Scott M. Dowell, DDS MS or any of their assignees to take photographs, slides and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial one option:

_____ I do not mind if my photographs are used in any of the above stated situations.

_____ I only agree to have my teeth shown without any identifying features.

Signed X_____ Date _____

If declining this consent, please initial here: _____