Welcome to
Dr. David R. Bowser III
Cosmetic & Family Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have questions we'll be glad to assist you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient Name: _____ Today's Date: _____
First MI Last

Home Address: _____ Date of Birth: _____
_____ Home Phone: _____
Business Name: _____ Business Phone: _____
SS#: _____ Email: _____ Cell Phone: _____
Sex: ☐ Male ☐ Female Please check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced
Name of responsible party: _____ ☐ Widowed ☐ Other: _____
Relationship to Patient: _____ Address: _____
Home Phone: _____ _____
SS#: _____ Date of Birth: _____

Patient Medical History

Primary Care Physician: _____
Address & Phone: _____

Please check if you have ever had any of the following:

____ Heart Disease	____ Anemia	____ Thyroid Disease
____ Heart Murmur	____ Liver Disease	____ High Blood Pressure
____ Heart Attack	____ Hepatitis	____ Low Blood Pressure
____ Chest Pain (Angina)	____ Bleed Easily	____ Stroke
____ Congenital Heart Defect	____ Jaundice	____ Stomach Ulcer/Problems
____ Rheumatic Fever	____ HIV/AIDS	____ Radiation Therapy
____ Mitral Valve Prolapse	____ Glaucoma	____ Cancer
____ Shortness of Breath	____ Kidney Disease	____ Recent Weight Loss
____ Sexually Transmitted Disease	____ Sinusitis	____ Swelling of Hands & Feet
____ Psychiatric Treatment	____ Diabetes	____ Respiratory Problems
____ Fainting Spells/ Dizziness	____ Convulsions	____ Tuberculosis
____ Asthma	____ Epilepsy	____ Allergies? To what? _____
____ Joint Replacement or Implant	____ Other _____	_____

____ Have you ever had any serious illness other than above?
Please explain: _____

____ Are you under the care of a physician at the present time?
Why? _____
Please list all medications you are currently taking: _____ _____
_____ _____ _____ _____ _____

____ Are you/ have you ever taken any medication to treat osteoporosis such as Boniva, Fosamax, Reclast, or Zometa?

____ Have you ever had a bad reaction to local anesthetic?
Please explain: _____

____ Have you ever had a bad reaction to any other drug?
Please explain: _____

____ Have you ever had any operations? What/when? _____
_____

____ Female: Are you now pregnant? What month? _____

To the best of my knowledge, the above confidential information is true.

Signature _____ Date _____

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Primary Dental Insurance

Name of insured: _____ Relationship to Patient: _____
First MI Last
Address (if different from patients): _____
State: _____ Zip: _____ _____
Date of birth: _____ SS#: _____ Group No. _____
Name of insurance company: _____ Phone No. _____
Address: _____ State: _____Zip: _____
Employer: _____ Phone No. _____
Do you have any additional insurance? ☐ Yes ☐ No If **YES**, complete the following:
Name of insured: _____ Relationship to Patient: _____
First MI Last
Address (if different from patients): _____
State: _____ Zip: _____ _____
Date of birth: _____ SS#: _____ Group No. _____
Name of insurance company: _____ Phone No. _____
Address: _____ State: _____Zip: _____
Employer: _____ Phone No. _____

Patient Dental History

Please check if any of the following applies to you:

Are your teeth sensitive to: ____ hot/cold liquids/foods ____ sweet/sour liquids/foods

Do you: ____ feel pain to any of your teeth ____ clench/grind your teeth
____ bite your lips/cheeks often

Do you have: ____ any sores/lumps in/near your mouth and/or ____ frequent headaches
____ Do your gums bleed while brushing/flossing?

Have you had: ____ any head, neck, or jaw injuries? And/or ____ Any orthodontic work

Have you ever: Experienced any of the following problems in your jaw?
A) Clicking B) Pain (joint, ear, side of face)
C) Difficulty opening/closing D) Difficulty chewing

____ Had any difficult extractions in the past
____ Had prolonged bleeding following extractions
____ Had instructions on the correct method of brushing your teeth
____ Had instructions on the care of your gums

Authorization

I certify that I have read and understand the information above, to the best of my knowledge; the questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Insured patients:
I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of insurance Co.
And assign directly to Dr. David Bowser III, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid my insurance.
I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agent for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that filing a claim with my insurance company does not relieve me from my responsibility for payment of all charges.

_ _____
Non-insured patients: Signature of Patient, Parent, or Guardian
I acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient.

_____ _____
Signature of patient, parent, or guardian Date