Douglas R. Dowdle, DMD
Julie L. Hess, DMD
Blake N. Imam, DMD

PATIENT INFORMATION

Name _____ I prefer to be called _____
First Name Initial Last Name

Sex: M F Age _____ Birth Date _____ /_____ / _____ Single Married Widowed Separated Divorced

Soc. Sec. # _____-_____-_____

Address _____

City _____ State_____ Zip _____ Home # _____ Cell # _____

E-mail _____ I would like to receive correspondences via e-mail Y N

Spouse Info _____ _____ _____
First Name Last Name Home Phone Cell Phone

Emergency Contact Person _____ Phone #_____

Patient Employed by _____ Occupation _____ Full Time Student Y N

Business Address _____ Business # _____

Who may we send a Thank You Gift to for referring you?_____

PRIMARY INSURANCE

Person Responsible for Account _____
First Name Initial Last Name

Relationship to Patient _____ Birth Date _____ / _____ / _____ Soc. Sec. # _____-_____-_____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone # _____

Person Responsible Employed by _____ Business # _____

Insurance Company _____Phone #_____ID#_____

Insurance Address _____ Group # _____

ADDITIONAL INSURANCE

Subscriber Name _____Relation to Patient _____ Birth Date _____ / _____ / _____

Address (if different from patient) _____ Soc. Sec. # _____-_____-_____

City _____ State _____ Zip _____ Phone # _____

Subscriber Employed by _____ Business # _____

Insurance Company _____Phone # _____ID#_____

Insurance Address _____ Group # _____

MEDICAL HISTORY

Physician's Name_____ Phone # _____

Are you under a physician's care now? Y N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____

Are you taking any medications, pills or drugs? Y N If yes, please list: _____

Have you ever had a joint replacement? Y N _____

Have you ever taken Bisphosphonate medications (ie. Fosamax, Boniva, Actonel) Y N _____

Have you taken Phen-Fen or Redux? Y N _____

Do you use tobacco? Y N _____

WOMEN: Are you: Pregnant/trying to get pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Are you allergic to any of the following? Latex Local Anesthetics Penicillin Erythromycin Tetracycline Aspirin Codeine Acrylic Metals Other If yes, please list _____

Do you have, or have you had, any of the following?

Y N AIDS/ HIV Positive	Y N Cortisone Medicine	Y N Hemophilia	Y N Radiation Treatments
Y N Anaphylaxis	Y N Diabetes	Y N Hepatitis A	Y N Recent Weight Loss
Y N Anemia	Y N Drug/Alcohol Abuse	Y N Hepatitis B or C	Y N Rheumatic/Scarlet Fever
Y N Arthritis/Gout	Y N Emphysema	Y N Herpes	Y N Rheumatism
Y N Artificial Heart Valve	Y N Epilepsy or Seizures	Y N High Blood Pressure	Y N Sickle Cell Disease
Y N Artificial Joint	Y N Excessive Bleeding	Y N Hives or Rash	Y N Sinus Trouble
Y N Asthma	Y N Excessive Thirst	Y N Hypoglycemia	Y N Stomach/Intestinal Disease
Y N Blood Disease	Y N Fainting Spells/Dizziness	Y N Irregular Heartbeat	Y N Stroke
Y N Breathing Problems	Y N Frequent Cough	Y N Kidney Problems	Y N Swelling of Limbs
Y N Bruise Easily	Y N Frequent Headaches	Y N Leukemia	Y N Thyroid Disease
Y N Cancer	Y N Glaucoma	Y N Liver Disease	Y N Tonsillitis
Y N Chemotherapy	Y N Heart Attack/Failure	Y N Low Blood Pressure	Y N Tuberculosis
Y N Chest Pains/Angina	Y N Heart Murmur	Y N Lung Disease	Y N Tumors or Growths
Y N Cold Sores/Fever Blisters	Y N Heart Pace Maker	Y N Pain Jaw Joints	Y N Ulcers
Y N Congenital Heart Disorder	Y N Heart Trouble/Disease	Y N Psychiatric Care	Y N Yellow Jaundice

Have you ever had any serious illness not listed above? Y N If yes, please explain _____

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_____

FINANCIAL POLICY

Payment is due in full at time of treatment – unless ***prior*** arrangements have been made.

As a courtesy to you, our office will bill your dental insurance company. It is your responsibility to know your insurance benefits, maximums, limitations and frequencies. Please be prepared to pay your portion of payment or co-pay at the time of service.

If your insurance denies claims, it is your responsibility to solve the problem with your insurance company. Our office will be happy to resubmit claims up to three times.

The responsible party agrees:

1. To make payment in full at time of treatment or service.
2. To be responsible for additional cost and/or responsible attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.
3. To pay a 40% collection fee, which will be added to the outstanding balance.
4. An additional finance charge of 1.5% per month (18% per year) which will be applied to any account that has not been paid in full after 60 days.

I understand that I am financially responsible for all charges whether or not paid by insurance. Also, I am aware that if I fail to show to my scheduled appointment or give less than a 24 business hour notice I will be charged a $25.00 no show fee for every hour I was scheduled.

Signature _____ Date _____