PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP | Heart Rate:

Height:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joints
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Diabetes
☐ ☐	Difficulty Breathing
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters
☐ ☐	Frequent Headaches

Y N	Conditions
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis A
☐ ☐	Hepatitis B
☐ ☐	Hepatitis C
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	Venereal Disease
☐ ☐	Yellow Jaundice

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Dr. Allison Fowler and Dr. Lindsey Walsh
8335 Walnut Hill Lane, Suite 105
Dallas, TX 75231

Dental History

Previous Dentist:_____ City: _____ How long? _____
Date of last cleaning: _____ Date of last x-rays: _____ Date of last treatment: _____
I routinely see my dentist every (circle one): 3 mo. 4 mo. 6 mo. 12 mo. Not Routinely
What is your immediate concern/reason for appointment? _____
_____

Check any of the following you have had or currently have:

__Mouth Discomfort
__Gum Abscesses
__Mouth Odor or Bad Taste
__Sensitive Teeth (hot, cold, sweets)
__Clicking, Popping, or Pain in Jaw Joints
__Grind or Clench your Teeth
__Wake with Sore Jaws
__Relatives with Loss of Natural Teeth
__Gums Bleed when Brushing
__Loose or Shifting Teeth
__Trouble in Chewing or Speaking
__Previous Periodontal (Gums) Treatment
__Orthodontic Treatment
__Bad Dental Experience
__Fear of Dental Treatment
__Cold Sores or Fever Blisters
__Other Oral Lesions
__Bruise Easily
__Complications With or Following Previous Dental or Oral Surgery Treatment

Please answer YES or NO to the following questions:

Do you like the way your teeth look? YES NO
Explain: _____
Are you happy with the color of your teeth? YES NO
Explain: _____
Would you like your teeth to be straighter? YES NO
Explain: _____
Do you have spaces between your teeth that you would like closed? YES NO
Explain: _____
Do you have missing teeth that you would like to replace? YES NO
Explain: _____
If you could change anything about your smile, what would you change?
Explain: _____

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General Consent

I authorize Dr. Fowler, Dr. Walsh, and/or their designated staff to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis I authorize Dr. Fowler, Dr. Walsh, and/or their designated staff to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that during treatment it may be necessary to change or add procedures to my treatment plan because of conditions found during treatment that were not discovered during examination. I give my permission to Dr. Fowler and/or Dr. Walsh to make all changes and additions to my treatment plan, as necessary.

Medical History: I have disclosed all of my medical history including, but not limited to, any and all drugs and medications that I am currently taking and have taken within the last 72 hours. I have also disclosed all medications, foods, and other substances to which I am allergic.

Radiographs: I understand that Dr. Fowler, Dr. Walsh, and/or their staff may need to take and evaluate x-rays to aid with proper diagnosis.

Local Anesthesia: I understand that local anesthesia is often used during dental treatment. I further understand that the risks of local anesthesia include, but are not limited to, dizziness, nausea, vomiting, increases or decreases in heart rate, allergic reactions that may require medical management or hospitalization, restricted mouth opening, accidental self-injury from biting numb cheeks, lips, or tongue, and/or temporary or permanent numbness, pain, or changed feelings in the teeth, gums, lip, chin, and/or tongue (including possible loss of taste).

No Guarantee: I understand that dentistry is not an exact science and that, therefore, dentists cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Insurance: I assign all dental insurance benefits to which I am entitled to the extent permitted under my insurance policy to Allison Fowler, DDS, PC, and authorize Allison Fowler, DDS, PC to submit claim forms and receive payments directly with the notation “signature on file”. I authorize release of my treatment records, x-rays, and other matters in my file deemed pertinent to my insurance as requested. I agree to be responsible for payment of all services rendered by Allison Fowler, DDS, PC on my behalf or to my dependents. I agree that I am responsible for all unpaid insurance claims.

Records: I understand that photographs, digital scans, study models, x-rays and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, professional publications (journals, magazines), and the practice website. If used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these materials.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct. My signature below also indicates that I am freely giving my consent to authorize Dr. Fowler and/or Dr. Walsh and any necessary assistant(s) to perform dental treatment.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN’S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

Dr. Allison Fowler and Dr. Lindsey Walsh
8335 Walnut Hill Lane, Suite 105
Dallas, TX 75231

Authorization for Disclosure of Health Information

I have been provided with and understand Allison Fowler, DDS, PC's Notice of Privacy Practices. Allison Fowler, DDS, PC may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as described in Allison Fowler, DDS, PC's Notice of Privacy Practices.

I give consent to Dr. Fowler, Dr. Walsh, and their team members to call me, leave voicemails, speak directly to family members answering my phone, and send mail and email to the addresses I provided, in reference to any items that assist the practice in carrying out treatment, payment, or operations, such as appointment reminders, billing information, insurance items, and any other information pertaining to my oral health.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Allison Fowler, DDS, PC is required to agree to the requested restrictions if they are reasonable. **The restrictions I request are:**

_____

_____

_____

I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

I have the right to request a copy of Allison Fowler, DDS, PC's Notice of Privacy Practices at any time.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct.

_____
PATIENT NAME

_____ _____
PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

Dr. Allison Fowler and Dr. Lindsey Walsh
8335 Walnut Hill Lane, Suite 105
Dallas, TX 75231

Authorization for Release of Dental Records From Previous Dentist

Please complete this form if you would like our office to request your dental records from your previous dentist. If your radiographs are older than one year or are not of diagnostic quality, we will take new radiographs at your appointment.

I authorize the release of my complete dental records, including radiographs, to

Allison Fowler, DDS, PC	214-368-0018
8335 Walnut Hill Lane, Suite 105	888-974-1763 fax
Dallas, TX 75231	Lia@allisonfowlerdds.com

Only digital radiographs in Carestream or .jpeg formats can be used.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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Dental Insurance and Financial Policy

Our office does not contract with any insurance company as a provider, nor do we have any specific information regarding your insurance benefits. We are **out of network**.

As a courtesy, we will assist you in filing electronic claims to your insurance provider for your "out of network" benefits. **We do not guarantee any payment from your insurance company.**

Please secure financial arrangements prior to your scheduled appointment. **If you use a dental insurance policy to assist in your payment, we will collect an estimated copayment at your appointment.**

If your insurance company reimburses us more than your remaining balance, we will mail you a reimbursement check within 10 business days of the day we receive the insurance reimbursement (see Example 1). **If your insurance company reimburses us less than your remaining balance, we will send you a bill for the remainder of the balance (see Example 2).** It may take up to 45 business days for us to receive a check from your insurance company.

	Treatment Cost	Your Estimated Copayment	Insurance Payment	Reimbursement Check to You	We Bill You
Example 1	$1000	$600	$450	$50	$0
Example 2	$1000	$600	$350	$0	$50

We will wait up to 45 business days for the "assignment of benefits" from your insurance company. After 45 business days, if the insurance company has not paid toward your unpaid balance, we may bill you for your entire balance.

Extended payments can be arranged by using Care Credit, an outside lending source. If outside financing is used, the entire fee will be applied to your Care Credit card and your insurance reimbursement will be mailed directly to you.

If you have questions regarding your account, please contact Lia at 214-368-0018. **Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.**

By signing below, I hereby certify that I have read and understand the above statements.

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

Dr. Allison Fowler and Dr. Lindsey Walsh
8335 Walnut Hill Lane, Suite 105
Dallas, TX 75231

Credit Card Auto-Charge Authorization

I authorize Allison Fowler, DDS, PC ("Company") to automatically charge the credit card that I have provided the Company to swipe one time, storing its information with the Company's third party credit card processor, and that is identified below. The Company will charge this card for all sums due, or to become due in the future, to the Company by me and any member of my family.

I understand that charges will be processed by the Company according to its regular billing practices. I agree that no additional prior notice needs to be, or will be, provided to the me before the Company charges my credit card. I agree that the re-submission of previously denied payment amounts may be charged at any time. I expressly authorize such charges to my credit card and further authorize the credit card information to be stored by the Company or its vendor.

I acknowledge that all purchases made from the Company are for dental services and/or dental products provided by the Company to me or my family. After insurance correspondence and/or payment have been received and applied to my account, any balance will be directly applied to this credit card. I understand that the Company will use its best efforts in keeping my credit card information secure. I waive any claim against the Company for any unauthorized third-party use of this information. I release the Company from liability for the manner in which the information is stored and for any unauthorized third-party use of this information. The Company will not knowingly allow any unauthorized party to have access to this information.

To discontinue the Company using my credit card, I will notify the Company in writing and the Company will process my request within its next billing cycle after paying all outstanding invoices that my family or I owes.

Last Four Digits of Authorized Credit Card: ___ ___ ___ ___

Expiration date: _____ Billing Zip: _____

_____
Signature Date

_____
Patient Name