Collinsville
FAMILY DENTISTRY
918.371.3774 Melissa Bowler DDS

About You

Patient Name:_____ Date of Birth:_____ Sex:____ Age:_____
Preferred Name:_____ Social Security #:_____
Address:_____ City: _____ State:____Zip:_____
Home Phone:_____ Cell Phone: _____ Email:_____
(Please circle your preferred method of contact)
Employer: _____ Work Phone:_____
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you have children? ☐ Yes ☐ No How many? ___
Spouse's Name:_____ Spouse's Contact Phone:_____
Emergency contact : _____Emer. Contact Phone:_____
Communication Preferences: In addition to the allowable disclosures in the Statement of Privacy Practices, I authorize the disclosure of my protected healthcare information to the following people: My spouse ☐ Yes ☐ No
Any member of my immediate Family ☐ Yes ☐ No Other individuals : (Please specify): _____
How did you hear about our office? _____

Account & Insurance Information

Guarantor: _____Relationship to Patient:_____
(Person responsible for account if different from patient.)
Billing Address:_____ City:_____ State:____ Zip:_____

Primary Insurance – Required to Bill Insurance
Please submit copy of card & photo ID to receptionist

_____
Subscriber's Name
____/____/____/ _____
Date of Birth Social Security Number
_____
Relationship to patient
_____
Name of Insurance Company
_____ _____
Group # ID # (Required to bill Ins.)

Secondary Insurance – Required to Bill Insurance
Please submit copy of card & photo ID to receptionist.

_____
Subscriber's Name
____/____/____/ _____
Date of Birth Social Security Number
_____
Relationship to patient
_____
Name of Insurance Company
_____ _____
Group # ID # (Required to bill Ins.)

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD. Thank you!

Office Financial Policies and Federal Truth-in-Lending Statement

*As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, 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 rendered.

(CONTINUED ON NEXT PAGE)

Dental History

Reason for today's visit:_____

Former dentist:_____ Date of last dental x-rays:_____ Date of last dental visit:_____

How frequently do you visit the dentist? ☐ 3 mos ☐ 6 mos ☐ 12 mos ☐ Other

How frequently do you floss? _____ How frequently do you brush?_____

Please check if you have/ had:	Yes	No		Yes	No		Yes	No
Bad Breath	☐	☐	Head/neck/jaw pain	☐	☐	Sensitivity?	☐	☐
Blisters on lips/mouth	☐	☐	Lip/ cheek biting	☐	☐	to: cold / heat / sweets / pressure		
Chew on one side of mouth	☐	☐	Loose teeth / broken fillings	☐	☐	(Circle any that apply.)		
Dry mouth	☐	☐	Teeth extracted/ injured	☐	☐	Are you satisfied with the		
Food collection between teeth	☐	☐	Mouth breathing	☐	☐	appearance of your smile?	☐	☐
Clench/Grind teeth	☐	☐	Orthodontic treatment	☐	☐			
Growths/sore spots in mouth	☐	☐	Nitrous Oxide	☐	☐			
Gums swollen/tender/bleeding	☐	☐	Periodontal Treatment	☐	☐			

Medical History

Physician's name:_____Phone:_____ Date of last visit:_____

	Yes	No	If yes, please describe:
Have you had any serious illnesses /operations/ hospitalizations?	☐	☐	_____
Do you use tobacco?	☐	☐	How often?_____
Do you use controlled substances?	☐	☐	Type & Frequency: _____

Women: Are you pregnant/ trying to get pregnant? Yes / No Taking oral Contraceptives? Yes /No Nursing? Yes /No

Are you allergic to any of the following? ☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ **NONE**

Please list any other Drug allergies:

Please check if you have/ had:	Yes	No		Yes	No		Yes	No
Allergies / hay fever / sinusitis	☐	☐	Diabetes	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Respiratory Disease	☐	☐
Arthritis / Rheumatism	☐	☐	Epilepsy / Seizures	☐	☐	Rheumatic/ Scarlet fvr	☐	☐
Artificial Heart Valves	☐	☐	Fainting	☐	☐	Slow healing wounds	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Swelling of feet/ankles	☐	☐
Abnormal Bleeding w/ surgery	☐	☐	Hepatitis Type____	☐	☐	Thyroid Problems	☐	☐
Blood disease / clotting disorder	☐	☐	High/Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Blood Transfusion	☐	☐	HIV/ Aids	☐	☐	Tumor / growth on		
Cancer	☐	☐	(Any) Immune Deficiency	☐	☐	head or neck	☐	☐
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Ulcer / colitis	☐	☐
Chemotherapy/ Radiation	☐	☐	Mitral Valve Prolapse	☐	☐	Other _____		
Cortisone Treatments	☐	☐	Osteoporosis * *	☐	☐	_____		

* *If yes, do you take Fosomax, Boniva, Actonel or any other medication containing bisphosphonates?

Please list ALL current medications you are taking: _____

I have read and answered the above questions to the best of my knowledge. I authorize the dentist and staff at Dental Solutions to perform procedures and treatment as needed for proper dental care.

_____ _____

Please Sign Date

MELISSA BOWLER DDS
1310 W Main Street
Collinsville, Oklahoma 74201
918-371-3774

Patient Name: _____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr. Melissa Bowler.
- I may refuse to sign.
- Expiration: 3 years from initial signature; insurance change; patient reaches age of 18.

- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

- ☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

_____ _____

Please ***print*** your name Please ***sign*** your name

☐ Patient ☐ Parent ☐ Guardian Other:_____

Financial Policy at Collinsville Family Dentistry

We accept: *Cash, Check, American Express, Discover, Mastercard, Visa* and *Care Credit*

We request 24 hours advance notice for canceling or rescheduling your appointment. If 24 hours is not given your account will be charged a broken appointment fee of $50.00

Returned checks and balances older than 90s days will be subject to collection fees and finance charges.

This agreement is to inform you of your financial obligation to our office. This financial agreement is intended to facilitate our ability to provide excellent service to you.

We will be happy to bill your insurance company on your behalf. However, all charges are your responsibility regardless of your insurance coverage. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your **ESTIMATED** copayment is due at the time service is rendered and may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Please do not hesitate to ask if you have any questions.

X _____