Welcome!

First of all, THANK YOU FOR CHOOSING US!
We look forward to working with you to maintain your optimum oral health.
If you have any questions we will be more than happy to assist you. Please begin by completing this form.

Patient Information

Today's Date:_____

Patient Name:_____
Title Last Name First Name MI

Gender (please circle) Male Female Age: _____ Birth date:_____/_____/_____ Marital Status:_____
Address:_____City:_____ State:_____ Zip:_____
Please provide your preferred method of contact. Automatic appointment reminders are sent to your cell phone number and/or email address if provided. If for any reason you'd refer not to receive them please let us know. Any text message sent by our office can receive two way messaging, so please feel free to respond without limitations! Save 941-923-3545 to your contacts now!
Home:(_____) - _____-_____ Cell Phone: (_____) - _____-_____ Work: (____)- _____-_____
Email Address:_____
Pharmacy Name/Location:_____ Pharmacy Phone Number: (_____) _____- _____
Emergency Contact:_____ Phone Number (_____) _____-_____
How did you hear about our practice?_____

Insurance Information

Do you have any dental insurance you'd like for us to file for you? (please circle) YES NO
If YES, please fill out the following information. Please provide us with a copy of your card if possible.

Insurance Company Name:_____ Subscriber ID#_____
Group Plan Name/Number:_____
Are you the subscriber? (please circle) YES NO If NO, please fill out the following information.
Policy Holder's Name:_____ Policy Holder's Birth Date:____/____/_____

Medical Information

Please list ALL medications you are currently taking: (if you have a list with you, we will gladly take a copy.)

Medication:	Medical Condition:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently under the care of a physician?(please circle) YES NO
If YES, please provide the following information.
Name of Physician:_____ Physician's Office Phone Number: (____) ____-_____
Any serious illnesses or hospital stays in the last year? _____
Have you been out of the country in the last 6 months? (please circle) YES NO

FEMALE PATIENTS ONLY: Pregnant? (please circle) YES NO Due Date?_____
Are you taking birth control? (please circle) YES NO

Do you have or have had any of the following problems? (please circle YES or NO for each)

Heart disease (murmur, high blood pressure, mitral valve prolapse)	YES	NO	Hepatitis A B or C (if YES please circle which type)	YES	NO
Stroke	YES	NO	Arthritis	YES	NO
Diabetes Type 1 or Type 2	YES	NO	Kidney Problems	YES	NO
Asthma (if YES, daily inhaler use? Y/N)	YES	NO	Ulcers	YES	NO
			T.B.	YES	NO
Seizures	YES	NO	Hip, Knee or Joint Replacements	YES	NO
Liver disease	YES	NO	Allergy to metals or jewelry	YES	NO
MRSA	YES	NO	HIV	YES	NO

Please let us know if you are taking any baby aspirin, regular aspirin or ANY blood thinners. (please circle) YES NO

to continue to page 2 please turn over...

Circle all allergic reactions to the following:

Local Anesthetics – Penicillin – Sulfa – Aspirin – Codeine – Narcotics – Latex –
Others: _____

Are you experiencing any dental problems? (please circle YES or NO for each or all that apply.)

Sensitivity to: Cold? – Heat?– Sweets?– Biting Pressure?
Unpleasant taste or odor in your mouth? YES NO
Do your gums bleed when brushing or flossing? YES NO
Do you experience jaw pain frequently? YES NO
Dissatisfied with color or shape of your teeth? YES NO
Have you ever had a "deep cleaning"? YES NO
Have you ever been diagnosed with Periodontal Disease? YES NO
Do you (please circle all that apply) Smoke/Dip? Grind your teeth? Snore?

Financial Policy

We understand things happen that require appointment cancellations, however we reserve time for **you, and you only.** Please be advised that our office does have a 48-HR cancellation policy and you may be charged a $50 late cancellation fee for any appointments that are broken outside those 48 hours. Our office can be reached at any time by call or text to 941-923-3545 to accept those cancellations.

Please be aware of your insurance policy at all times! As a courtesy we will verify that we are preferred provider of your insurance plan, obtain a basic breakdown of your plan benefits and limitations prior to your first appointment. Please understand per your insurance company that all benefits quoted are an **estimate of benefits** and not a guarantee of payment.

Payment is due at the time services are rendered. This includes all past due balances, unmet deductibles, co-payments and any other charges that were not covered by your insurance policy. Please be aware that you may be charged a late fee of 1.5% per month that will be assessed on past due accounts over 30 days and collections charges and/or attorney fees. Thank you!

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by my dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform my dentist. I authorize my dentist to release my information necessary to secure the payment of benefits from my insurance company. I understand that I am financially responsible for all charges if they are not paid by my insurance company.

Acknowledgment of Receipt of Notice of Privacy Practices

Purpose: We are required by law to maintain the privacy of, and provided individuals with, this notice of our legal duties to privacy practices with respect to protected health information or PHI. You have been given this form on **Page 3** of this packet or on your clipboard if you happen to be in our office. If you have any objections to our form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main office number.

This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document out good faith effort to obtain that acknowledgment. **You may refuse to sign this acknowledgment with understanding that we will be unable to file your dental insurance claim or send any of your personal information to any referring providers if necessary.**

I _____, have received a copy and have full understanding of
Dr. Thomas A Bowles' Notice of Privacy Practice.

Signature:_____ Date: _____

I _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name:_____ Relationship:_____
Name:_____ Relationship:_____

Notice of Privacy Practices

Dear Valued Patient,

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment and any other healthcare operations that are permitted or required by law.

Effective April 14th, 2003 The Secretary of Health and Human Services passed a new government rule and speculated new regulations regarding the Heath Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". It is our policy to properly determine appropriate use of Personal Health Information (PHI) in accordance with governmental rules, laws and regulations. Our office wants to ensure that our practice never contributes in anyway to the growing problem of improper disclosure of PHI.

By signing the consent you allow your dentist, his staff and others outside our office that may be involved in your care and treatment to use and disclose your PHI for treatment, payment and other healthcare operations. This also implies to others involved in your healthcare such as family, friends, or other persons you may identify that you request to be involved in your healthcare, emergencies or upon professional judgment by the dentist and substantial communication barriers involving the patient and the dentist.

When required by Law, Public Health, Communicable Diseases, Health Oversight, Abuse and Neglect, Legal Proceedings, Law Enforcement, Organ Donors, Funeral Directors, Military Activity, we may use or disclose your Protected Health Information without your consent or authorization.

At any time during your treatment you may refuse to sign the consent in which we may not use or disclose your PHI, we must ask that you state your reasoning in writing. Under this law, if you refuse to disclose your PHI, we have the right to refuse treatment to you. If consent was signed prior to determining refusal of PHI, you may not revoke actions that have already taken place in regards to disclosure of your PHI. At any time you as the patient have the right to request and receive information of certain disclosures of your PHI. At any time you as the patient have the right to request and receive information of certain disclosures we have made regarding your PHI as described in this Notice of Privacy Policy.

As a team we strive to achieve the very highest standards of ethics and integrity in providing service and care to our patients. It is in sincere regards to this plan and our policy to listen to our staff as well as our patients without any thought of penalization if they feel that in an event or instance we are compromising our policy of integrity. We most kindly welcome any input or questions you may have regarding our policy of integrity and want to thank you for being among our most highly valued patients.

Dr. Thomas A. Bowles