



MICHAEL J BOWMAN, DDS, MS, PLLC
MICHAEL D BROOKS, DMD, MS, PLLC

PATIENT INFORMATION RECORD

NAME DATE

DATE OF BIRTH SEX SOCIAL SECURITY

HOME ADDRESS HOME PH

CITY STATE ZIP CELL/PAGER OTHER PH

EMPLOYER WORK PH

DENTAL INS.

PRIMARY SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

INSURANCE CO. NAME GROUP # PHONE NUMBER

INSURANCE CO. ADDRESS CITY STATE ZIP

SEC. DENTAL INS.

SUBSCRIBER NAME SOCIAL SECURITY # DATE OF BIRTH

INSURANCE CO. NAME GROUP # PHONE NUMBER

INSURANCE CO. ADDRESS CITY STATE ZIP

SPOUSE/PARENT NAME DOB

SPOUSE/PARENT EMPLOYER WORK #

REFERRED BY

FAMILY DENTIST

PURPOSE FOR YOUR VISIT

X SIGNATURE OF PATIENT/GUARDIAN DATE



MICHAEL J BOWMAN, DDS, MS, PLLC
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Medical History

PATIENT NAME: _____

Have you been under the care of a medical practitioner during the past two years? YES NO

If YES, for what? _____

PHYSICIANS'S NAME _____ PHONE _____

ADDRESS _____

DATE OF LAST MEDICAL EXAM: _____

PLEASE LIST ALL MEDICATIONS/DRUGS YOU ARE CURRENTLY TAKING: (Name, strength & dosage)

Have you been hospitalized or had any operations? _____

Have you become sick, shown an ALLERGY to, or been told not to take any of the following:

- YES NO - PENICILLIN OR OTHER ANTIBIOTICS
YES NO - ASPIRIN, CODEINE OR OTHER PAIN MEDICATIONS
YES NO - NOVOCAIN, XYLOCAINE OR OTHER MEDICATIONS

LIST ALL KNOWN ALLERGIES: _____

- YES NO - Do you smoke? How much? _____ per DAY or WEEK
YES NO - Daily alcohol intake _____

WOMEN: Are you PREGNANT? YES _____ Months NO NURSING? YES NO
Taking BIRTH CONTROL PILLS? YES NO

COMPLETE THIS SECTION IF YOU ARE PRESENTLY WEARING DENTURES OR PARTIALS

DENTURE/PARTIAL HISTORY

Are you presently wearing dentures/partial? Upper? _____ Lower? _____
(Year Made) (Year Made)

Are you happy with your current prosthesis, if not please explain?



DR. MICHAEL J. BOWMAN
DR. MICHAEL D. BROOKS

PLEASE **CHECK** WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT:

- | | |
|---|--|
| <input type="checkbox"/> Heart surgery, disease, attack | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Allergies or hives |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Mitral Valve prolapse | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Rheumatic fever or rheumatic heart disease | <input type="checkbox"/> Hepatitis A-infectious/Hepatitis B -serum/Hepatitis C |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Cortisone medication | <input type="checkbox"/> Cold sores/fever blisters |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Diet – special/restricted | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prolonged bleeding after injury or surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Yellow jaundice |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fainting/dizzy spells |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Nervous/anxious |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psychiatric/psychological care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bisphosphonates meds (Fosamax or Zometa) |
| <input type="checkbox"/> Herpes | |

Do you have any disease, condition or problems that haven't been listed?

Please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health and/or medication.

PATIENT/GUARDIAN SIGNATURE

_____ DATE _____



MICHAEL J BOWMAN, DDS, MS, PLLC
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I am aware of my rights to privacy regarding my protected health information, under the Health Insurance Portability & accountability Act of 1996 (HIPAA). I understand that this information can and will be used for:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

Please list any other person(s) that we may share your information with:

Please note that a copy the *Notice of Privacy Practices* which contains a complete description of the uses and disclosures of my protected health information is available upon request. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____ Date: _____

If signing for a patient, your relationship to Patient: _____

For office use only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- The patient refused to sign.
- Communication barriers
- Emergency situation