

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form
completely in ink. If you have any questions or need assistance, please ask us -
we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Time ☐ Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Time 4:33 PM

Fowler Family Dentistry
Eaglesoft Medical History

Date 8/13/2025

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?

☐ Yes ☐ No

If yes

Have you ever been hospitalized or had a major operation?

☐ Yes ☐ No

If yes

Have you ever had a serious head or neck injury?

☐ Yes ☐ No

If yes

Are you taking any medications, pills, or drugs?

☐ Yes ☐ No

If yes

Do you take, or have you taken, Phen-Fen or Redux?

☐ Yes ☐ No

If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Yes ☐ No

If yes

Are you on a special diet?

☐ Yes ☐ No

Do you use tobacco?

☐ Yes ☐ No

Do you use controlled substances?

☐ Yes ☐ No

If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Other?

☐

If yes

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

AIDS/HIV Positive

☐ Yes ☐ No

Alzheimer's Disease

☐ Yes ☐ No

Anaphylaxis

☐ Yes ☐ No

Anemia

☐ Yes ☐ No

Angina

☐ Yes ☐ No

Arthritis/Gout

☐ Yes ☐ No

Artificial Heart Valve

☐ Yes ☐ No

Artificial Joint

☐ Yes ☐ No

Asthma

☐ Yes ☐ No

Blood Disease

☐ Yes ☐ No

Blood Transfusion

☐ Yes ☐ No

Breathing Problems

☐ Yes ☐ No

Bruise Easily

☐ Yes ☐ No

Cancer

☐ Yes ☐ No

Chemotherapy

☐ Yes ☐ No

Chest Pains

☐ Yes ☐ No

Cold Sores/Fever Blisters

☐ Yes ☐ No

Congenital Heart Disorder

☐ Yes ☐ No

Convulsions

☐ Yes ☐ No

Cortisone Medicine

☐ Yes ☐ No

Diabetes

☐ Yes ☐ No

Drug Addiction

☐ Yes ☐ No

Easily Winded

☐ Yes ☐ No

Emphysema

☐ Yes ☐ No

Epilepsy or Seizures

☐ Yes ☐ No

Excessive Bleeding

☐ Yes ☐ No

Excessive Thirst

☐ Yes ☐ No

Fainting Spells/Dizziness

☐ Yes ☐ No

Frequent Cough

☐ Yes ☐ No

Frequent Diarrhea

☐ Yes ☐ No

Frequent Headaches

☐ Yes ☐ No

Genital Herpes

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Hay Fever

☐ Yes ☐ No

Heart Attack/Failure

☐ Yes ☐ No

Heart Murmur

☐ Yes ☐ No

Heart Pacemaker

☐ Yes ☐ No

Heart Trouble/Disease

☐ Yes ☐ No

Hemophilia

☐ Yes ☐ No

Hepatitis A

☐ Yes ☐ No

Hepatitis B or C

☐ Yes ☐ No

Herpes

☐ Yes ☐ No

High Blood Pressure

☐ Yes ☐ No

High Cholesterol

☐ Yes ☐ No

Hives or Rash

☐ Yes ☐ No

Hypoglycemia

☐ Yes ☐ No

Irregular Heartbeat

☐ Yes ☐ No

Kidney Problems

☐ Yes ☐ No

Leukemia

☐ Yes ☐ No

Liver Disease

☐ Yes ☐ No

Low Blood Pressure

☐ Yes ☐ No

Lung Disease

☐ Yes ☐ No

Mitral Valve Prolapse

☐ Yes ☐ No

Osteoporosis

☐ Yes ☐ No

Pain in Jaw Joints

☐ Yes ☐ No

Parathyroid Disease

☐ Yes ☐ No

Psychiatric Care

☐ Yes ☐ No

Radiation Treatments

☐ Yes ☐ No

Recent Weight Loss

☐ Yes ☐ No

Renal Dialysis

☐ Yes ☐ No

Rheumatic Fever

☐ Yes ☐ No

Rheumatism

☐ Yes ☐ No

Scarlet Fever

☐ Yes ☐ No

Shingles

☐ Yes ☐ No

Sickle Cell Disease

☐ Yes ☐ No

Sinus Trouble

☐ Yes ☐ No

Spina Bifida

☐ Yes ☐ No

Stomach/Intestinal Disease

☐ Yes ☐ No

Stroke

☐ Yes ☐ No

Swelling of Limbs

☐ Yes ☐ No

Thyroid Disease

☐ Yes ☐ No

Tonsillitis

☐ Yes ☐ No

Tuberculosis

☐ Yes ☐ No

Tumors or Growths

☐ Yes ☐ No

Ulcers

☐ Yes ☐ No

Venereal Disease

☐ Yes ☐ No

Yellow Jaundice

☐ Yes ☐ No

Have you ever had any serious illness not listed above?

☐ Yes ☐ No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:

Patient's Name _____
Last First Middle Initial Date of Birth

In order to update your medical record, it is important for us to know if you have ever received a type of medication known as Bisphosphonate. These medications are used in the treatment and prevention of osteoporosis, high blood calcium due to malignancy and bone disease associated with breast cancer, prostate cancer and multiple myeloma. This information will assist us in providing your dental care.

Please circle **Yes or No** for any of the following medications that you are currently taking **or** have taken in the past.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Circle One</u>	
Actonel	Risedronate	Yes	No
Aredia	Pamidronate	Yes	No
Bonefos	Clodronate	Yes	No
Didronel	Ibandronate	Yes	No
Fosamex	Etidronate	Yes	No
Fosamax Plus D	Alendronate	Yes	No
Skelid	Tiludronate	Yes	No
Zometa	Zolendronic Acid	Yes	No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

BISPHOSPHONATE MEDICATION UPDATE

FOWLER

FAMILY DENTISTRY

Written Financial Policy

Thank you for choosing Fowler Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of \$500.00 or more.

- Convenient Monthly Payment Plans¹ from Care Credit

- o Allow you to pay over time
- o No annual fees or pre-payment penalties
- o No interest on select plans

Please note:

Fowler Family Dentistry requires payment prior to the completion of your treatment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

Fowler Family Dentistry charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment" I, have

been informed of this office's Notice of Privacy Practices.

Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

Authorization to Release Dental Record Information HIPAA

Patient's First and Last Name: _____

Date of Birth: _____

I authorize to release all my dental records to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient or Parent/Guardian Signature: _____ Date: _____

*Authorization Expires Three Years After It Is Signed