PATIENT INFORMATION

Patient Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex: M ☐ F ☐ Marital Status S ☐ M ☐ D ☐ W ☐ Birth Date _____

Social Security# _____ Email Address _____

Emergency Contact _____ ***Phone*** _____ ***Relation to you*** _____

May we confirm your appointment by text messages? Yes ☐ No ☐

Patient Employed By: _____

PARENT / SPOUSE INFORMATION

Parent / Spouse Name _____ SS # _____ Phone _____

Parent / Spouse Employed by _____ Work Phone _____

Other Parent Employed by _____ Work Phone _____

PRIMARY DENTAL INSURANCE (If you have a 2nd Insurance please let us know)

Insurance Company _____ Group # _____

Employer _____

Policy Holder Name _____ Date of Birth _____

Policy Holder SS# _____ Insurance ID # _____

Policy Holder Address (if not same) _____ Phone _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE - *PLEASE READ CAREFULLY*

I authorize the release of any information regarding my treatment to any other doctor or dentist that Dr. Nowlin refers me to for additional treatment or consultation. While a treatment plan may be established and presented, it is possible that it may be altered due to subsequent findings during the course of treatment. **IF I CANNOT KEEP MY APPOINTMENT I AGREE TO PROVIDE AT LEAST 24 BUSINESS HOURS NOTICE OR A CANCELLATION OR BROKEN APPOINTMENT FEE WILL BE INCURRED BY ME.**

I, the undersigned, assign directly to Dr. Robert Nowlin and/or Dr. Lisa Nowlin all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy to me, Nowlin Dental Clinic may process insurance claims and submit them to my insurance carrier. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** Drs. Nowlin and Nowlin Dental Clinic do not represent any insurance carrier and make no representation as to what services will or will not be covered by my insurance. Any **"estimate"** I receive from Nowlin Dental Clinic is based on information supplied by my insurance carrier and is, as stated, merely an **"estimate"**. If the insurance payment is not as it was represented to Nowlin Dental Clinic, Drs. Nowlin and the Clinic are not responsible. The Clinic's fees are set beforehand and have nothing to do with my insurance carrier. Any disagreements I may have about which procedures have or have not been covered must be resolved by me with my employer or insurance carrier and do not change my responsibility for all charges incurred. Any costs incurred in collecting a past due account will be my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay the patient portion due at each appointment.

Responsible Party Signature Relationship Date

MEDICAL HISTORY

PATIENT NAME: _____ **DATE:** _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Dr.:_____ **Town:**_____ **Date of last visit:**_____ **No Medical Dr.** ☐

	Yes	No		Yes	No		Yes	No
Under Medical Treatment	☐	☐	Head Injury	☐	☐	Medical Marijuana Permit	☐	☐
Take Osteoporosis Drug (past or present)	☐	☐	Joint Replacement	☐	☐	Ever used Meth	☐	☐
Take Blood Thinners (not including Aspirin)	☐	☐	Metal in Body	☐	☐	Substance Abuse Treatment	☐	☐
Take Prescriptions or OTC Meds	☐	☐	Major Surgery/Hospitalization	☐	☐	In a Pain Management Program	☐	☐

Do you have or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Autoimmune Disease	☐	☐	Liver Disease	☐	☐	Do you use any form of Tobacco? ☐ Smoke ☐ Vape ☐ Smokeless Tobacco Age Started: _____	☐	☐
Low Blood Pressure	☐	☐	Decreased Immunity	☐	☐	Kidney Disorder	☐	☐			
Heart Ailment	☐	☐	Wound/Healing Problems	☐	☐	Colitis/Intestinal Disorder	☐	☐			
Heart Attack	☐	☐	'Common' Arthritis	☐	☐	Hospitalized for C. Diff	☐	☐			
Stroke	☐	☐	Rheumatoid Arthritis	☐	☐	Stomach Disease/Ulcers	☐	☐	Have you used Tobacco in the past but Quit? Year Quit: _____	☐	☐
Heart Surgery	☐	☐	Cancer	☐	☐	Anorexia/Bulimia	☐	☐			
Congenital Heart Disorder	☐	☐	☐ Chemo ☐ Radiation			Frequent Headaches	☐	☐			
Pacemaker or Defibrillator	☐	☐	Persistent Cough	☐	☐	Seizure Disorder	☐	☐	Any Medical Condition Not Listed (please list) _____ _____	☐	☐
Bleeding/Blood Disorder	☐	☐	Respiratory Disorder	☐	☐	Bell's Palsy	☐	☐			
Cardiologist's Name: _____			Sleep Apnea	☐	☐	Alzheimer's Disease	☐	☐			
			Asthma	☐	☐	Mental or Learning Disability –Please List _____	☐	☐	**Women are you:**		
Thyroid Problems	☐	☐	Sinus Trouble	☐	☐				Pregnant	☐	☐
Diabetes ☐ Type I ☐ Type II ☐ Take Insulin	☐	☐	Tuberculosis	☐	☐				Trying to get pregnant	☐	☐
			MRSA Infection	☐	☐	Anxiety	☐	☐			
			AIDS/HIV Positive	☐	☐	Depression	☐	☐	Nursing	☐	☐
Hypoglycemia	☐	☐	Hepatitis ☐ A ☐ B ☐ C	☐	☐	Glaucoma	☐	☐	Taking Oral Contraceptives	☐	☐
Cold Sores	☐	☐									

Are you allergic to any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Latex Gloves	☐	☐	Codeine	☐	☐	Benadryl	☐	☐	Acrylic	☐	☐
Penicillin	☐	☐	Aspirin	☐	☐	Local Anesthetic	☐	☐	Nuts – Please List	☐	☐
Sulfa Drugs	☐	☐	Ibuprofen	☐	☐	Metal of any kind	☐	☐			

Other Allergies – Please List: _____

Patient/Guardian Signature: _____ **Date:** _____

For Office Use Only _____ ASA PS

_____

_____

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete copy of the Clinic's Notice of Privacy Practices is posted in the facility. You are welcome to take a copy of the Practices. By signing below you acknowledge that you have viewed a copy of our Notice of Privacy Practices.

X

Signature of Patient or Parent if Patient is a Minor or Incompetent Date

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ BY CHECKING HERE, I CONSENT TO THE FOLLOWING: Nowlin Dental, PLLC or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. Nowlin Dental Clinic, PLLC may also contact me to check on my progress after treatment. Nowlin Dental Clinic, PLLC may:

Call and Text me Only Call me Only Text Me

These are the phone numbers at which Nowlin Dental Clinic can contact me and leave a detailed message:

( ) _____ Home Work Cell

( ) _____ Home Work Cell

( ) _____ Home Work Cell

IF YOU ALLOW US TO TEXT APPOINTMENT CONFIRMATIONS TO YOU, WE WILL AUTOMATICALLY SEND YOU CONFORMATION TEXT MESSAGES AT 1 WEEK, 2 DAYS, AND 1 HOUR BEFORE YOUR APPOINTMENT.

_____ BY CHECKING HERE, I GIVE CONSENT TO BE CONTACTED BY EMAIL FOR THE FOLLOWING: Appointment and Treatment information and for our newsletters, surveys, promotions, etc. EMAIL ADDRESS: _____
Your information will never be given out or sold.

I allow you to give my clinical information to or answer questions from.

☐ Spouse: (Name) _____

IF YOU ARE THE PARENT/GUARDIAN OF A MINOR (UNDER 18) YOU MUST WRITE YOUR NAME IN THE SPACE BELOW.

☐ Parent: (Name) _____

☐ Child: (Name) _____

☐ Other: (Specify) _____

☐ None: _____

X

Print Patient's Name Patient's Date of Birth

X

Patient / Guardian Signature Today's Date

PATIENT NAME: _____

DATE: _____

DENTAL HISTORY

Purpose of today's appointment: _____

	YES	NO
Do you think your teeth are negatively affecting your health?	☐	☐
If yes, please explain: _____		
Do you have any unhealed / inflamed areas in / around your mouth?	☐	☐
If yes, please explain: _____		
Have you experienced any growth or sore spots in your mouth?	☐	☐
If yes, please explain: _____		
Have you ever had a cold sore or fever blister?	☐	☐
Have you ever had TMJ or jaw-joint problems?	☐	☐
Have you ever had dental anesthetic (Novocain, Xylocaine, etc.)?	☐	☐
Is it hard for you to get numb?	☐	☐
Any reactions to dental anesthetic?	☐	☐
Any difficult extractions in the past?	☐	☐
Prolonged bleeding following extractions in the past?	☐	☐
Do your gums bleed?	☐	☐
Have you ever been told you have gum disease?	☐	☐
Have you ever had treatment for gum disease?	☐	☐
Have you ever seen a gum specialist (Periodontist)?	☐	☐
Is any part of your mouth sensitive to biting, cold, hot, or sweets?	☐	☐
Do you have any oral or facial piercings?	☐	☐
Are you tense before or during dental treatment?	☐	☐
Have you ever fainted or passed out in a dental office?	☐	☐
Have you ever been told to take antibiotics before ALL dental treatment?	☐	☐
Have you ever had orthodontic (tooth straightening) treatment?	☐	☐
Have you ever had a lump in your mouth (not including tooth abscess)?	☐	☐
Do you have, or have you ever had loose PERMANENT teeth?	☐	☐
Have you ever had a bad experience in a dental office? Explain below:	☐	☐
If yes, please explain: _____		
Do you have any other dental condition / symptoms not mentioned?	☐	☐
If yes, please explain: _____		

When was your last cleaning? _____

When was your last X-rays? _____

When was your last dental visit? Month and year: _____

What dentist did you see? _____

Are you pleased with your smile? ☐ ☐

If no, what would you change if you could? _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

☐ GUM TREATMENT ☐ WHITENING ☐ STRAIGHTENING ☐ CAPS/CROWNS

PATIENT/GUARDIAN SIGNATURE: DATE:

WELCOME TO NOWLIN DENTAL CLINIC
WE'RE GLAD YOU ARE HERE!

PLEASE READ AND SIGN OUR POLICIES……..

1. WE UNDERSTAND THAT SOMETIMES THINGS COME UP AND CANCELLATIONS ARE UNAVOIDABLE. WE HAVE NO PROBLEM WITH CANCELLATIONS MADE WITH AT LEAST 24 BUSINESS HOURS NOTIFICATION BECAUSE WE CAN USUALLY FILL YOUR APPOINTMENT SLOT. IF YOU NO SHOW OR CANCEL YOUR APPOINTMENT WITHIN 24 BUSINESS HOURS YOU WILL BE CHARGED A BROKEN APPOINTMENT FEE OF $50-$400 DEPENDING ON THE AMOUNT OF TIME ALLOTTED FOR YOU. THIS MUST BE PAID IN ORDER TO SCHEDULE AN APPOINTMENT FOR ANY PERSON ON YOUR ACCOUNT. BECAUSE WE ARE CLOSED ON FRIDAY, IN ORDER TO CANCEL A MONDAY APPOINTMENT WITHOUT INCURRING A FEE, YOU MUST CANCEL BY NOON ON THE PREVIOUS THURSDAY .

2. WE TRY TO ACCOMMODATE REQUESTS FOR LATE APPOINTMENTS, HOWEVER, THESE ARE LIMITED IN NUMBER. WE ARE UNABLE TO OFFER ANOTHER LATE APPOINTMENT IF YOU HAVE BROKEN A LATE APPOINTMENT IN THE PAST. WE WILL BE GLAD TO PROVIDE YOU OR YOUR CHILD WITH A WRITTEN EXCUSE FOR MEDICAL TREATMENT.

3. AS A COURTESY TO OTHERS, WE HAVE PROVIDED BENCHES IN THE FOYER FOR YOUR CELL PHONE CONVERSATIONS.

4. AS A COURTESY TO YOUR DR. AND HYGIENIST, PLEASE TURN OFF CELL PHONE SOUND AND VIBRATE.

5. DUE TO THE RISING COST OF BILLING, PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT.

6. ONLY PATIENTS ARE ALLOWED IN THE OPERATORIES (TREATMENT ROOMS). THIS POLICY WAS IMPLEMENTED BECAUSE:

a. THERE IS LIMITED SPACE IN THE OPERATORIES.
b. EXPENSIVE EQUIPMENT HAS BEEN BROKEN BY CURIOUS CHILDREN WHO WERE WITH A PARENT OR SIBLING IN THE OPERATORY.
c. WE STRIVE FOR A GERM FREE ENVIRONMENT IN OUR OPERATORIES. MORE PEOPLE MEAN MORE GERMS.
d. IT IS DISTRACTING TO THE DOCTOR, HYGIENIST, AND THE PATIENT.
e. THE FOLLOWING PATIENTS MAY HAVE ONE PERSON WITH THEM:
CHILDREN 6 AND UNDER
PATIENTS WHO ARE PHYSICALLY OR MENTALLY CHALLENGED.

WE UNDERSTAND YOUR CONCERN FOR YOUR LOVED ONE. THEREFORE ONE ADULT FAMILY MEMBER MAY ACCOMPANY THE PATIENT TO THE OPERATORY TO BE SEATED, RETURN TO THE RECEPTION AREA, AND THEN AFTER THE PROCEDURE, MAY AGAIN GO TO THE OPERATORY TO VISIT WITH THE DOCTOR OR HYGIENIST.

7. MANY INSURANCE COMPANIES ARE NOW REFUSING TO GIVE COVERAGE INFORMATION TO MEDICAL AND DENTAL OFFICES AND PREAUTHORIZATIONS MAY NOT BE ACCURATE.

WE DO OUR BEST TO ESTIMATE HOW MUCH YOUR INSURANCE WILL PAY, BUT REMEMBER THAT YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF TREATMENT EVEN THOUGH OUR ESTIMATE MAY BE WRONG.

8. RECORDING OF THE CONVERSATION BETWEEN OUR DOCTORS OR STAFF AND OUR PATIENTS IS NEVER ALLOWED IN THIS FACILITY. IF IT IS DISCOVERED THAT A PATIENT OR GUARDIAN IS RECORDING, THE VISIT WILL BE IMMEDIATELY TERMINATED AND A FOLLOW-UP VISIT WILL BE SCHEDULED. A REPEAT OCCURANCE MAY RESULT IN DISCHARGE FROM THE PRACTICE.

THANK YOU FOR YOUR COOPERATION WITH OUR POLICIES!

_____

Patient or Parent **Date**