

## 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. <input type="checkbox"/>
	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>
Are you in good health at this time	<input type="checkbox"/>	Had major surgery	<input type="checkbox"/>
Under medical treatment	<input type="checkbox"/>	Joint replacements	<input type="checkbox"/>
Take osteoporosis drug (Bone Building)	<input type="checkbox"/>	Had a head injury	<input type="checkbox"/>
Take blood thinners (not aspirin)	<input type="checkbox"/>	Had substance abuse treatment	<input type="checkbox"/>
Take any prescriptions or OTC drugs	<input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs	Do you use any form of tobacco
			<input type="checkbox"/> Smoke <input type="checkbox"/> Vape <input type="checkbox"/> Smokeless Tobacco
			Have you ever used meth
			<input type="checkbox"/>
			Do you have a medical marijuana permit
			<input type="checkbox"/>
			Are you in a pain management program
			<input type="checkbox"/>

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

Mental /Learning Disability	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>
If yes, explain _____		<input type="checkbox"/> Chemo <input type="checkbox"/> Radiation		Heart Condition or Heart Surgery	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	If yes, explain _____	
Anxiety Disorder	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Cardiologist Name _____	
Hepatitis	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		MRSA Infection	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Take Insulin	
Kidney Disease	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	Any medical condition not listed	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	Bell's Palsy	<input type="checkbox"/>	If yes, explain _____	
Glaucoma	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>		
Bulimia or Anorexia	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<b>Women are you:</b>	
Respiratory Disorder	<input type="checkbox"/>	Colitis or Intestinal disorder	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Stomach Disease / Ulcers	<input type="checkbox"/>	Trying to get pregnant	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	Nursing	<input type="checkbox"/>
Wound or Healing Problems	<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	Taking oral contraceptives	<input type="checkbox"/>
Blood Disease / Bleeding Disorder	<input type="checkbox"/>	Decreased Immunity	<input type="checkbox"/>		
Cold Sores or Fever Blisters	<input type="checkbox"/>				

## Are you allergic to any of the following?

	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>	<u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>
Latex Gloves	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	Codeine	<input type="checkbox"/>
Acrylic	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>
Metal of any kind	<input type="checkbox"/>	Benadryl	<input type="checkbox"/>
		Sulfa Drugs	<input type="checkbox"/>
		Ibuprofen	<input type="checkbox"/>
		Pine Nuts	<input type="checkbox"/>

Other Allergies - Please List: \_\_\_\_\_

Patient/Guardian Signature:

Date:

For Office Use Only

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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Do you have any unhealed / inflamed areas in / around your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Have you experienced any growth or sore spots in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Have you ever had a cold sore or fever blister?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had TMJ or jaw-joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had dental anesthetic (Novocain, Xylocaine, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Is it hard for you to get numb?	<input type="checkbox"/>	<input type="checkbox"/>
Any reactions to dental anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding following extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had treatment for gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever seen a gum specialist (Periodontist)?	<input type="checkbox"/>	<input type="checkbox"/>
Is any part of your mouth sensitive to biting, cold, hot, or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any oral or facial piercings?	<input type="checkbox"/>	<input type="checkbox"/>
Are you tense before or during dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fainted or passed out in a dental office?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told to take antibiotics before ALL dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (tooth straightening) treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a lump in your mouth (not including tooth abscess)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had loose PERMANENT teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bad experience in a dental office? Explain below:	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Do you have any other dental condition / symptoms not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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. THIS POLICY WAS IMPLEMENTED BECAUSE:

THERE IS LIMITED SPACE IN THE OPERATORIES

EXPENSIVE EQUIPMENT HAS BEEN BROKEN BY CURIOUS CHILDREN WHO WERE WITH  
THEIR PARENT OR SIBLING IN THE OPERATORY

WE STRIVE FOR A GERM FREE ENVIRONMENT IN OUR OPERATORIES. MORE PEOPLE MEAN  
MORE GERMS

IT IS DISTRACTING TO THE DOCTOR, HYGIENIST, AND THE PATIENT.

THE FOLLOWING PATIENTS MAY HAVE ONE PERSON WITH THEM:  
CHILDREN 6 AND UNDER  
PHYSICALLY OR MENTALLY CHALLENGED PATIENTS

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!**

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**Patient or Parent**

**Date**