



Dr. Robert D. Bowman, DMD
5955 Weddington Road, Suite 101, Wesley Chapel, NC 28104
704-776-9424
www.forestlakedental.com

Patient Information and Consent Form

Date: _____

Patient Name: _____ Preferred Name: _____
Last First MI
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: ____/____/____ Driver's State & Number _____

Phone (Home): _____ (Cell): _____ (Work) _____ ext. _____
Text message Accepted? Yes or No

E-Mail Address _____ Email message Accepted? Yes or No

Address: _____
Street Apartment #
City State Zip Code

Responsible Party

Name: _____
 Male Female Self Spouse Other _____

Social Security #: _____ Birth Date: ____/____/____ Driver's License State: ____ No. _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #
City State Zip Code

Employer Name: _____ Phone Number: _____ Ext. _____
Employer Address: _____
Street City State Zip Code

Insurance Information

Primary Policy Holder: _____
Last First MI

Birth Date: _____ SS#: _____

Insurance Plan Name: _____ Insurance Phone Number: _____

Subscriber ID #: _____ Group #: _____

Employer Name: _____ Phone Number: _____ Ext _____

Patient's relationship to insured: Self Spouse Child Other _____

Referral Information

How did you hear about our office?
 Street Sign Sign on Building Internet Site: _____
 Flyer in Mail Other: _____
 Name of person or office referring you to our practice: _____

Health History Information

Patient Name _____ Date _____
Reason for today's visit: _____ Date of Last Dental Cleaning Visit: _____

What would you like to improve about your smile? _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Dental Anxiety | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes <u>Type 1</u> or <u>2</u> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> S.T.D: Type: _____ |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tobacco - Smoke |
| <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco - Snuff |
| Type: _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Teeth Grinding/ Clench |
| Type: _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | | <input type="checkbox"/> Ulcer |
| Type: _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | OTHER: |
| Date: _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer: Type: _____ | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sleep Apnea | |

PRE-MEDICATION REQUIRED? Yes No Reason: _____ Prescription: _____

****WOMEN ONLY:** Are you pregnant? Yes _____ No _____ If yes, Due Date: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

• List of Current Medications: _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such Dental care to the third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: ____/____/____ Relationship to Patient: _____
Signature of patient or legal guardian



Office Policy/Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

INSURANCE

Our office files insurance only as a courtesy to our patients. We will initially ask you only for your estimated co-payment but please understand that this is **ONLY AN ESTIMATE** based upon the information available to us. Therefore, the patient/primary policy holder is responsible for any unpaid balances.

CANCELLATION POLICY

We appreciate you as a patient and have reserved this valuable time just for you. In order to serve our patients better we cannot accommodate last minute schedule changes. It does not allow us time to offer that appointment to another patient. If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hours notice.

Missed appointments without 48 hour notice will charged a \$40.00 cancellation fee.

****Please remember that other patients may have desired the time you had reserved****

PAYMENT OPTIONS

Our office accepts checks, all major credit cards (Visa, Master Card, American Express and Discover). We also offer no interest lines of credit through Care Credit or Chase Health Advance. Please be aware that unless arrangements are made in advance, **payment is due at time of service**. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. **I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.**

****Returned Checks will be charged a \$25.00 return check fee****

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Forest Lake Dental or any of its employees to use telephone, email, letters, text messages or any other electronic forms of communication to discuss this statement, appointment information, or my dental treatment.

I certify that I have read the above conditions of treatment and payment and agree to their content.

Date: _____

Signature of patient or legal guardian

Forest Lake Dental

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

- Other: _____

Prepared By _____

Signature _____

Date _____

Forest Lake Dental Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Forest Lake Dental is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
--	--

Voice Mail

Appointments

Other _____

Other person (s) (provide name and phone number)(Example: Spouse, Parent, Stepparent, Friend, Relative etc.)

Financial

Treatment

Email communication-Provide email address*

Financial

Treatment

Appointment reminders

Breach notification

*For email communication to occur, please accept the disclosure below:

Text communication – Provide number *

Appointment reminder

Other: _____

*For text communication to occur, accept the disclosure below:

For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Photo of patient received by patient or legal guardian

May be posted in office

Photo taken by staff (Example: pre/post procedure)

May be posted on website or social media

Other _____

Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)



Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

_____ may release the following information:

(Name of Prior Dental Office)

- Entire record Financial records Office visit notes
 X-Rays

Entity or person who will receive the information:

Name: Forest Lake Dental

Address: 5955 Weddington Road, Suite 101, Wesley Chapel, NC 28104

Phone: 704-776-9424

Send the information electronically. Email address: **smile@forestlakedental.com**

For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2016